Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician/ Medical **Examiner**

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex. miner must be notified at

Maryland 21215-0036

Baltimore,

Box 68760

P.O. |

Records,

Division of Vital

Pnysician/ Medical Examiner

attending physician and for use as the burial-transit that the death certificate be executed ed by the a detached f signed I The law requires icate has been sig page 2 should b certificate within 24 hours after death.

To the Funeral Director; After this certific: completed filled in by the funeral director, or Attending Physician: Hospital

for State Registrar 24501 Decedent's Name (First, Middle, 1 2. Date of Death 3. Time of Death 0:06 AM Eacility Name (if not institution, 4b. City, Jown, or Location of Death 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 1 🔀 M 2 🗆 F Months Hours Min. (Month, Day, Year) 217-38-1136 72 21,1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Md. Baltimore Dundalk 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2706 Page Drive 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married by Yes 2 X No 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Engineer <u>Machinist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Redemann Sr. Isabell Cummins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Wise Ave. Dundalk, Md. 21222 Lisa Redemann Daughterinlaw 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30, 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Baltimore, Maryland Signature of Funeral Service License Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Duy to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) MD

State Registrar

the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

NOW

Faroline

31. Date filed (Month, Day, Year)
AUG 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day OD II lucy 5.458 William Boyd Rhodes, Sr. Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner BALTIMORE WOCHENGTON MEDICAL HNNE CHEN 7. Age (In yrs. last birthday) 73 Yrs. If Under If Under 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Country) Maryland 1 🗷 M 2 □ F Months Hours 03/26/1938 219 26 2328 **Director** Usual Residence of Decedent 10a. State 10b. County 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified Maryland Baltimore Baltimore 1 Yes 2 X No 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S. 2771 Yarnall Road 21227 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. , or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give aryland 21215-0036 1 Yes 2 X No Specify. White Specify "natural" 3 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Health and Mental Hygiene. General Motors Auto Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Rhodes Vivian Ridgley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Barbara Rhodes / Wife 2771 Yarnall Road Baltimore, Maryland 21227 Baltimore, Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 08/01/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory かまり 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Fineral Service Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner ii any, ieading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has ball director, page 2 sl autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 29c. License number 1451 44 Vompleted ca.. address of person who

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State	of Maryla			of Health <i>of Death</i>			gier 2 e () Reg. No.		24503
Physici /Medi		Decedent's Name (First, Mice		aine Dorot	hy Sweet				2. Date of De Month July	Day	Year 1	3. Time of Death 4:00 P
Examir		4a. Facility Name (If not institut Glen Burnie Heal	lth & Rehab	ilitation		Glen I				Anı	inty of Death ne Arund	
Funeral Director		5. Social Security Number 093–16–2082 Usual Residence of Decedent	6. Sex 1 ☐ M 2 X		s. last birthday) Yrs.	If Under 1 Y Months D	year If Unde	Min.	8. Date of Bir (Month, Da Aug 18,	y, Year)		place (State or Foreintry) Jersey
Maryland a-f ehow	tor	10a. State 10b. Coun	ty Arundel	10c. C	City, Town or Lo		Glen Burn	nie			1	0d. Inside City Limi
th with the 23a or 28a	Funeral Director	10e. Street and Number	3 Cedar Dri	ve		10f. Zip Co	ode	21060		10g. Citizen USA	of What Cour	ntry?
72 hours after death with the Maryland netural', or Iteme 23a or 28a-f ehow dical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 M. 3 X Widowed 4 Divorce	Armed 1 7 If Yes	ecedent Ever in Forces? es 2 (1) No Give or Dates:		Was Decedent f Yes, specify 1 ☐ Yes 2 🗓	t of Hispanic O Cuban, Mexica No <i>Specif</i> y		ify Yes or No ican, etc.)		Race - Americ Black, White, ec <i>ify:</i> Wh	
d within 72 ho giene. er then *netur	Completed		ent's Education nest grade complete) Colleg	e (1-4or 5+)	(Give	DO NOT use r	done during mo		g	Anne A	of Business/In Arundel of Educ	County
buld be filed Mental Hygin arked other atic event, II	To Be C	17. Father's Name (First, Middle		l W. Gardn	er		18. Moth		(First, Middle, cet Grav	Maiden Sun lick	name)	
Heelth and tem 25 to Heelth and tem 27 to mother traum		Michael L. Sulliv 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other	ran (Son—:	om State		lar Drive	r place)		Marylan te	d 21060 20c. Locati		own, State
permit. Pages Department of Important; If I eny injury or once.		21. Signature of Funeral Service		rin E Ecke	r 22	. Name and A	Address of Faci	lity McC	ully-Po	lyniak l	Funeral 21122	Home, P.A.
cate be executed by Medical Examiner the buriat-transit the buriat-transit	dicai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	Myoc	identification of: Lette	al nsic	cufa cufa lellil ler	tus	iên			Approximate Interval Between Onset and Death 2 year 7 2 year 2 year
The law requires that the death certificate hes been signed by the attending a cage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1	outcome of preg re birth 2 □ Fe egnant at time of iknown	tal death 3	Ectopic pregr Other (specia				23d.	Date of deliver Month	ery Day Year
quires that n signed b ud be deta	d by PI	Part II. Other significant condi	tions contributing t	o death but not re	sulting in the u	nderlying caus	se given in Part	I.	1	obacco use o		he cause of death?
: The law requir cate hes been si page 2 should	Complete								24a. Was auto perio 1 Yes	an 2- psy prmed? 2 100	4b. Were auto prior to co death? 1 □ Yes	opsy findings availal impletion of cause of
Physicien: this certificatal director.	To Be	25. Was case referred to medic examiner? 1 Yes 2	Hospital:	□Inpatient 2(☐ ER/Outpatier	it 3 DOA	1 0.1		Check only o	2.0	Other (Special	(y)
After Aune	Certification:	3 ☐ Suicide 6 ☐ Coul	stigation	ite of Injury Ionth, Day Year) ace of Injury - At iilding, etc. (Spec	28b. Time of Injury home, larm, str	М	Injury at Work? 1 Yes 2]No		Street and Nown, State)		al Route Number,
To the Hospital or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a Certifier 1 Certific (Check only 2 Medical Medical Certific Service)	ing Physician: To al Examiner: On the and m	the best of my kr e basis of examination	nawledge death	r occurred at t vestigation, in	he time. Jate a my opinion, de	and place at	id dua to the d at the time,	cause(s) and date and pla	manner as a ice, and due t	itelad o the cause(s)
To th within To th compl	Me	29b. Signature and title of certain			-	29c. Li	cense number	601	9	29d. Date si	gned (Month,	Day, Year)
		30. Name and address of person	n who completed o	ause of death (Ite	em 23a) (Type. H 19 h	Print) -	CLYM	ade	Ter.	ira (MD	21225
Sta Registr		31. Date liled (Month, Day Yea		gistrar's Sign	hature	11			·	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24504 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Saavedra Maria 201^{Yea} P^{N} 26, 9:44 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2😾 55 Months 06/16/1956 Director n/a Bolivia Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD Montgomery 28a-f 1 Tres 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral 13804 Vista Drive 20853 Bolivia 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black White etc. ģ 1 Never Married 2 Married Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 X Yes 2 ☐ No Specify: Bolivian White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) be filed within N/A N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ Anibal (unkn.) (unkn.) permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or Athana Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Roman / Friend 13804 Vista Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rinal Journey Crem. 1 Burial 2 Cremation 3 Removal from State 7/29/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CVA Sequentially list conditions, if any, leading to immediate cause Enter courselying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ing physician a Physician/Medical death certificate be Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Pneumocystis, Jurvoci Pneumonia, Brain Cancer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Minknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Seizure Disorder 24a Was an autopsy 2 No 2 🗶 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2**XX**Io Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation Director: in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

To the Hospital or Attending Physician: The law ithin 24 hours af the Funeral Di empleted filled in 2

M 1168096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Satyam Shah, 1500 Forest Glen Road, Silver Spring, MD

State Registrar

Medical

29a. Certifier

(Check only one

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

July 27, 2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24505 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 Somervill 5:55 ам Rose Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mount Airy Kline Hospice House Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Min. 80 366-28-9394 0870671930 **Director** unkin Usual Residence of Deceder 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lovettsville VA Loudon 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20180 39331 Rodeffer Road death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐**x**No If Yes, Give Year or Dates. Maryland 21215-0036 filed within 72 hours after White 1 Yes 2 XNo Specify "natural", 3 Widowed 4 Divorced Specify. Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meany injury or other ပ Josephine Kuprewicz Orlando Smith 19a. Informant's Name/Relationship (Type, Print)
Jeffrey L. Hall/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39331 Rodeffer Road, Lovettsville,, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Woodbine, MD Final Journey Crematory : 4 Donation 5 Other (Specify) 8/2/2011 Signature of Funeral Service Licensee Dorota, Marshall 22. Name and Address of Facility Maryland Cremation Services Baltimore, MD 21203 P.O. Box 1413 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASYATIC Immediate Cause (Final Physician/ OVARIAN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nonsequence of): Examin -transit Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 🗌 Yes 2 🗌 No Yes the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Tes 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA hours after death.
uneral Director: After this of filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔀 Natural 5 Pending injury Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a

To the Funeral L

completed filled Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) MA D31761 ress of person who completed cause of death (Item 23a) (Type, Print) SOI WISEVENTH STI State Registrar

			For State	State of M	arylan					and M	lental Hy	giene	01		2450	6
			Registrar 1. Decedent's Name (First, Middle, La	est)		Cer	tificat	e or L	Jeath	_	2. Date of De	Reg. No.	-		3. Time of Deat	th
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	Examir	er	4a. Facility Name (if not institution, giv	,					Location o			4c. (County of I		0.1477	
Tass	Funeral		Holy Cross Hosp 5. Social Security Number 6.5	Sex 7. Aq	e (In vrs. k	ast birthday)		S11Ver 1 Year	er Sp		8. Date of Bir	th	Mont		ery lace (State or For	eian
	Director		581-03-8620	1 X] M 2 □ F	78	Yrs.	Months	Days	Hours	Min.	Jan. 2	9, 19	33 P	Count		Jigi i
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	or 28	흅	10e. Street and Number	000180 0				p Code				10a, Citiz	en of Wha	t Coun		. 110
	with with s 23a ust b	era	9200 Edwards Way	#313					20783			Uni	ted S	tat	es	
	death item ner m	Completed by Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S		Vas Dece f Yes, spe	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - A			
36	after al", or xami	d b	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give			Yes	2 🗆 No	Specify:	_	to Rica	s	Black, V pecify:	Whi		
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ary	and Me		19a. Informant's Name/Relationship (19b. Mailir	na Addres	is (Street a	and Numbe	er or Rura	l Route Numbe	er. City or T	own. State	a. Zip C	ode)	
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Baltimore,	pe 1 ar t of He if iten or oth		20a. Method of Disposition 1 ☐ Burial 2 又 Cremation 3 ☐	Removal from State		lace of Dispo emetery, cren			e)		Date	20c. Loc	ation - Cit	y or To	wn, State	
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	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	SEPS:	IS											
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Box	eath of atter	Physician/M	in the past 12 months?	1 Live Birth 4 Pregnant a	2 🗌 Feta it time of c	aldeath 3 ☐ death 5 ☐	Ectopic Other (s	pregnanc pecify)	у				Month		Day Year	
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Ä	sician: The law certificate has lirector, page 2 s		25. Was case referred to medical	ı				00 01		4- (011	perfo 1 ☐ Yes	XX No			2 🗆 No	
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Division of Vital Records,	I or Attend after death Director: /	Certificate:	4 Homicide determined		ury - At ho c. (Specify	me, farm, stre	et, factor	y, office			28f. Location (9 City or Tow		Number o	r Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			sician: To the best of												
	the Ho	Medical	(Check 2 Medical Exam	niner: On the basis of e rse Practioner: To the	xamination	and/or invest	igation, in	my opinio	n, death oc	curred at	the time, date a	and place,	and due to	the cau	ise(s) and manner	stated
	To the within to To the comple		29b. Signature and title of certifier	11			29	c. License		2			signed (N			
	1		pr	- 17	N			טטע	063343)		Jt	JLY 2	0,	2011	
$\sqrt{\lambda}$			30. Name and address of person who IRINA RUBAN M.D.		eath (Item	23a) (Type, F	rint)	SILVE	ER SPI	RING	MD 2	0910				
1	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture		V L								
	Registra		AHC 0 2 2011 /2		Mar	Red										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Josephine Mary Schuman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Hmore Daware pital sedale Social Security Number Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
(Ar. 19, 1927 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Min. Country **Director** 148-18-3319 Vrs 84 New Jersev Usual Residence of Decedent 28a-f show 10a State 10h. County 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Harford 1 Yes 2 No Joppa 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 1411 Old Mountain Road South 21085 USA items (11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2X No Specify: "natural", Maryland 2121*6*/003 Completed 3 ☒ Widowed 4 ☐ Divorced Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) I Hygiene. Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If item 27 is marked other thar Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Angelo R. Bondio Maria Donata Fanelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Old Mountain Road South, Joppa, MD 21085 Leslie A. Hook / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other placel Holly Hill Mem. Gdns. 8-3-11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland permit. I Signature of Funeral Service Licen McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ailure Heart disease or condition resulting in death) Medical **Examiner** Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner igned by the attending physician and be detached for use as the burial-transit monare ension u Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 2 No been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours are death

To the Funeral Director: After this certificate has I performed 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work 2 Acciden Accident Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title/of 29c. License number of death (Item 23a) (Type, Print) son who completed c 21237 Franklin State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 Wilda Garlene Spicer 6:56 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10300 Crain Hwy. Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 20, 9. Birthplace (State or Foreign **Funeral** Day, Year, 1916 1 □ M 2 🎇 F West Virginia 95 Director 579-20-1470 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2 🔀 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10300 Crain Hwy. 20772 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: "natural", White 3 XXWidowed 4 □ Divorced Specify: Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Bank Teller Banking of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nimrod Strawderman Frances Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other trai 4310 Estate Dr. Huntingtown, MD 20639 James Spicer (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 f X Burial 2 \Box Cremation 3 \Box Removal from State Department of Important: If any injury or MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) August 3, 2011 Cheltenham, MD Signat of Funeral Service License MO1555 22. Name and Address of Facility Lee Funeral Home. Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cardispulm Glasse

Due to (or as a Insequence of): disease or condition 47known resulting in death) Medical Core brova helan aci. de Examiner Sequentially list conditions, If any, leading to humedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 5 Other (specify) Year eral Director. After this certificate has been signed by the a filled in by the funeral director, p. ge 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pulmon Hypertersin Division of Vital Records, or Attending Physician: T e law equires 1 Yes 2 No 3 Probably 4 Unknown 3 Chronic Kidy din 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

ROINTAN FARAHI FAR 31. Date filed (Month, Day, Year) -- - -

12150 Annapolis Rd Smit 200 Glanda MO 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

D43446

1-05569		Please Ty	pe or Print in E	Black In	delible in	c. Ensur	e All Copi	es Are L	egible).	
auline Schissle	et		tate of Maryland				id Mental F	łygiene		2011	24509
		1- For State Registrar		Cer	tificate of L	Death		700 0	Reg. No.		
Physici Medical Exami		Decedent's Name (First, Midd		ne Hel	en Shifl	ett		2. Date of De Month July 25,	Day	Year	3. Time of Death 2311 hrs
		4a. Facility Name (if not institution		r)		-	Location of Dea	th	4c.	. Counfy of Death	
		Harbor Hospital Cente				Baltimore	Train and		2:	N/A	
Funeral Director		5. Social Security Number		ge (In yrs. Ia	ist birthday)	If Under 1 Year Months Day			,	DD/YYYY) 9. Birt Foreig	n
Director		218 70 5651	1 M 2 X F	53	Yrs.			11/.	16/19	Cor	untry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location						10d, Inside City Limits
.	_	Maryland Ann	e Arundel		Baltimo	re					1 Yes 2 X No
Aaryland 28a-f show 1 at ooce.	cto	10e. Street and Number			1	Of. Zip Code			10g. Citiz	zen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at ooce.	Director	323 W. River	rview Road			212	225			U.S.A.	
with th ns 23a xe noti		11. Marital Status	12. Was Deceder				spanic Origin? (S		No-		can Indian, Black,
death or iten	Funeral	1 Never Married 2 AM	Armed Forces	s? 2 X No	If Yes,	specify Cuba	n, Mexican, Puert	o Rican, etc.)		White, etc.	
after after iner	by F		orced If Yes, Give Yeer or Dates:			es 2 X No					nite
hours oatu		15. Decedent's Education (Spe					ition (Give kind of b. DO NOT use re		16b. K	(ind of Business/li	ndustry
hin 72 e. than	ple	Elementary/Secondary (0-12)	College (1-4 o	(5+)	Homema	aker				Own Ho	ome
5-0036 led within 72 hours at Hygiene. other than "oatural the Medical Examio	Completed	17. Father's Name (First, Middle,	Last)				18.Mother's Nam	e (First, Middle	, Maiden	Surname)	
21215-0036 ould be filed within 7 I Mental Hygiene, n marked other than ic event, the Medica	Be		Melvin W	. App1	legarth		Rı	ith G.	Price	2	
21, hould be is mar	101	19a. Informant's Name/Relations	ship (Type, Print)			ddress (Stree	et and Number or	Rural Route N	umber, Ci	ty or Town, State,	Zip Code)
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "ostural", or items 23a or 28a-f she trammatic evect, the Medical Examiner must be notified at occ		David Shifle	ett / Husban				view Roa				yland 21225
nore, MD 2121 signs I and 2 should be fi nt of Health and Mental 1: If item 27 is marked other traumatic evect,		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from S		lace of Disposition rematory or other		metery,	Date	20c. L	ocation - City or	Town, State
imore Pages I: nent of H aot: If if		4 Donation 5 Other Sa		Bay	yview Cr			/01/201	1		e, Maryland
Baltimore, permit. Pages 1 at Department of Het Important: If the injury or other tr		21. Signature of Funeral Service	Lidensee			e and Addres				1 Servic	
		TUMO ()	laringe	d the death							yland 2122! Approximate Interval
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	ami	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of);				_		
xecuted n and l - transit	Exa	events resulting in death) Last	d.								
	dical	X UNPENDED	x AMENDED I to	em# 1 a	as noted	ger me	,g918 8-	-2-11 s	m		
Box 68760, e death certificate be the attending physic ed for use as the bur	an/Medi	IF FEMALE:	23c. If yes, outco	ome of pregn	ancy	<u> </u>			23d	. Date of delivery	
68 certificanting se as t	ian	23b. Was decedent pregnant in the past 12 months?	I LIVE DITTI	at time of dea	2 Fetal		Ectopic pregn	ancy		Month D	ay Year
SOX leath e atter	Physici	1 Yes 2 No 9 ✔ Unk	·	at time of d oc	ath 5 Other	(Specify)					
O. B at the de 1 by the tached 1		Part II. Other significant condit	tions contributing to dea	th but not re	sulting in the und	erlying cause (given in Part I.	23e, Did	tobacco u	use contribute to t	he cause of death?
ires that the signed by the detach	d by							1 □ Y	es 2	No 3 Prob	ably 4 🗸 Unknown
ords, w requir	lete							24a. Wa	s an opsy		opsy findings available ompletion of cause of
Records, The law require ficate has been si	Completed							per	formed?	death?	
Vital Rec ysiciao: The his certificate director, page		25. Was case referred to medica			<u></u>	26.Place	of Death (Check				
Vita bysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5	Resider	nce 6 Other:	
Division of Vital Lal or Attending Physician Is after death. al Director: After this cert led in by the funeral director led in by the funeral director.	i.	27. Manner of Death	28a. Date of In (Month, Day)	jury Year)	28b. Time of Inju	y 28c. Inju	ry at Work?	28d. Describe	e how inju	ry occurred	
teodi for: /	atio	1 Natural 5 Pend 2 Accident Inves				10	Yes 2 No				
ivis or At after d Direc	tifica	3 Suicide 6 Coul	ld not be 28e. Place of	Injury - At ho	me, farm, street, f	actory, office b	ouilding, etc.	2Bf, Location or Town,		nd Number or Rur	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physiciae: The law requires that the death certificate be e within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial	Certification:	4 Homicide	rmined (Specify)		_						
he Ho in 24 h			hysician: To the best of r miner:On the basis of ex								
To the Company of the	Medical	29b. Signature and title of certifie	and manner stated			29c. Licens				Date signed (Mon	
	-	D 118				O.C.				26, 2011	,,,,
		30. Name and address of person	who completed cause of	death (Itam 1	23a)						
Levil		Pamela E. Southall, M				V. Baltimor	e Street, Balt	imore, MD	21223		
7	ato	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	e /	•					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland		artment of I		tal Hygier	2011	24510
	Physicia Medic Examir	cal	1. Decedent's Name (First, Middle, Last) GEORGE WILLIAM SCHWEIT 4a. Facility Name (if not institution, give street and number)	2612	4b. City. Town, o		Date of Death Month	Day Year 2011	3. Time of Death
-	Funeral Director		Howard County General Hospital 5. Social Security Number 137-38-1344 64	st birthday) Yrs.		ott City If Under 24 Hrs. 8.0	Date of Birth Month, Day, Yea	Howard g. Birt	hplace (State or Foreign Intry)
		Director	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation tt City		encer 3,	1940 Masim	10d. Inside City Limits 1 ☐ Yes 2 ☒No
	th with the I ns 23a or 2 must be no	Funeral Di	10e. Street and Number 3143 Old Oak Drive			21042		Citizen of What Cou USA	untry?
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 XNo	dispanic Origin? (Specify Y an, Mexican, Puerto Rican Specify:	es or No- , etc.)	14. Race - Amer Black, White Specify: WI	
Baltimore, Maryland 21215-0036	within 72 ho giene. ner than "nat t, the Medica	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years 8 years	(Give k life. DC	dent's Usual Occup kind of work done (O NOT use retired) YSICIAN	during most of working		. Kind of Business I	•
yland	uld be filed I Mental Hy narked ott natic even	To Be	17. Father's Name (First, Middle, Last) George Martin Schweitzer			18. Mother's Name (Firs Elizabeth	,	,	
e, Maı	and 2 shored the shored the shored sh		19a. Informant's Name/Relationship (Type, Print) Pamela Ann McCarthy wife 20a. Method of Disposition	3143	Old Oak I	and Number or Rural Rou Drive, Ellic	ott Cit	y, MD 2	1042
ltimor	nit. Page 1 artment of ortant: If it injury or o		1 Rurial 2 XCremation 3 Removal from State	view C	sition (Name of natory or other place rematory	2011	'' Ba	Location - City or I	Maryland
Ba	permi Depai Impo any ir		23a. P. m. Enter the disease, or complications that caused the death	Do not ente	onnelly I	ss of Facility Funeral Home ers Point Ro	of Dun	dalk,P.A. dalk,Md.	21222 Approximate
مسد	ate be executed Medical Examiner the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last A HEMODYNAM Due to (or as a consequence cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	ence of): P.t. ence of):	APS E				Interval Between Onset and Death
. Box 687	ne death certificate y the attending phy ched for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 [Ectopic pregnand Other (specify)	Sy		23d. Date of deli	very Day Year
ords, P.O	requires that the been signed by should be deta	leted by Pl	Part II. Other significant conditions contributing to death but not resu KIDNCY TRANSPIANT PAION DUT PUMMAY GREGISM	Iting in the ur	nderlying cause giv			2 No 3 □ Pro	the cause of death? bbably 4 Unknown bpsy findings available
tal Rec	Physician: The law r r this certificate has b gral director, page 2 sl		25. Was case referred to medical		26. Pl		autopsy performed? I ☐ Yes 2 ☑	prior to co death?	ompletion of cause of
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	유	Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E	28b. Time of injury	28c. Injun work M 1	4 Nursing Home 5 y at	escribe how inj	ury occurred and Number or Rura	
	To the Hospita within 24 hours To the Funeral completed filler	Medical	29a. Certifier (Check only one) 1	and/or investi	igation, in my opinion leath occurred at the 29c. License	on, death occurred at the tir e time, date and place, and e number	ne, date and placed due to the cause 29d. E	ce, and due to the ca e(s) and manner as s Date signed (Month,	ause(s) and manner stated tated. Day, Year)
1			30. Name and address of person who completed cause of death (Item 2 MAITHELD JASEN CLUY 36 5575 COAE	23a) (Type, Pr	rint) (siansia, M		J	11931 20	

State Registrar

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0^{Month} 30 Physician/ Year Priscilla Ann Starck ŽÖ11 3:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) *10 at te of Birth *10 Oonth, Day, Year) *10 4 1959 Birthplace (State or Foreign Country) Funeral Social Security Number 6. Sex 1 M 2 X F Days Hours Min. Director 213-80-4189 51 MD Usual Residence of Decedent or 28a-f show 10b. County 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Essex Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 items 23a Funeral STank, Priscilla 07/30/2011 168 1/2 Riverside Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after a and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nursing Assistant Medical injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Howard Sr. Dorothy Swanson permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Starck Husband 168 1/2 Riverside Rd, Essex MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-2-2011 Baltimore, Maryland Signature of Puner | Servic - License 22. Name and Address of Facility Connelly Funeral Home of Dundalk, 7110 Sollers Point Rd Dundalk, MD M01176 23a. Part 1. shock Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician System entra Nervous Himorrhag Medical resulting in death) Due to (or as a consequence of): Examiner ING Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be the 98 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Year Pregnant at time of death detached 9 Unknown P. 0. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Wunknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case erred to medical or Attending Physician: director, To Be 26. Place of Death (Check only one) examiner: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 - ER/Outpatient 3 - DOA filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred AS After t injury ☐ Natural 5 Pending work? Bolu 2 Accident 1 Yes 000 22007 2 No 24 hours after death Funeral Director: A 129/2011 Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 168 R (UENS DE RESERVENT DE RESE 28e 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completed fil 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death tem 23a) (Type, Print) 31. Date filed (Month, Pay, Year) AUG 0 2 2011 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :32 PM OHN IHOMAS, SHAW Juli 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALT IMOIZE HARBOR HOSPITAL N/A If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Days Min Months Hours (Month, Day, Year) 06/19/1951 **Director** 291 50 1880 60 Ohio Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits PA. Fayette New Salem 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38 North Mill Street 15468 U.S. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Designer Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Patrick Shaw traumatic Virginia Lee Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Shaw / Brother 8400 Bent Maple Court Blacklick, Ohio 43004 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State injury or 07/27/2011 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland Signature of Funeral Service Licenses Gonce Funeral Service, P.A. Baltimore, Maryland 21225 22. Name and Address of Facility any 4001 Ritchie Highway 23a. Part 1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Interval Between Onset and Death Physician/ MIDBRAIN STROKE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner R +ENSION Sequentially list conditions, if any leading to immediate Examine for each monsposition of cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform certificate Yes 2 No 1 🗌 Yes 2 👺 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work' ☐ Accident ☐ Suicide Investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

State Registrar

DHMH 17 Rev 7/2009

JENNIFER

31. Date filed (Month, Day,

AUG

30015. HAWOVER ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KNOULTON

RES OOI

Boutimore MD

21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 24513 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Margaret May Strickler 12-50A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALINE ARUNDE CHEN BURNIB SACTIMORE WASHINGTON MEDICAL CENTER Social Security Number 8. Date of Birth (Month, Day, June 27 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2XXF Months Hours Director 214-22-0088 85 June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Directo 28a-f 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with 1 th and Mental Hygiene. 23a 27 is market, or items 23a 72 is market when than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral 8 Woods Drive 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Give 1 ☐ Yes 2 🔀 No Specify: White Completed 3XXWidowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Bookkeeper</u> Container Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Reinhardt Naomi Johanna Fangman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mr. Paul Strickler/ Son 134 Teal Drive Pasadena, MD 21122 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of aug Date 1 20c. Location - City or Town, State Department of H Important; If ite any injury or ot cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Leaksville UCofC Cem. 2011 Luray, VA 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd AVe SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or ion plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ HEUMONIAS disease or condition Medical resulting in death) **Examiner** TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Tes 2 No 3 Probably been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation the within 24 hours after dear To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature title of certifier

Registrar

State

Glen Burnie

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

rich Scanland	1- For State Registrar	tate of Maryland /		ent of Health ar ate of Death	nd Mental		eg. No. 20	11 2451
Physician ledical Examine		die,Last) Scanland				2. Date of Dea Month July 31, 20	Day Year	3. Time of Death 0622 hrs
	4a. Facility Name (if not instituti 7881 Walnut Grove F	on, give street and number)		4b. City, Town, o	or Location of De		4c. County of I	
Funeral	Social Security Number		(In yrs. last birth	nday) If Under 1 Ye			th (MM/DD/YYYY)	9. Birthplace (State or
Director	216-11-9134 Usual Residence of Decedent	1XM 2 F	27	Yrs. Months Da	ys Hours I	Min. 03/31	/1984	Foreign Washingtor Country) DC
w any	10a. State 10b. County		10c. City, Town o			-		10d. Inside City Limits
the Maryland or 28a-f sho tiffed at once.	MD Ann 10e. Street and Number	e Arundel	Se	Vern		11	0g. Citizen of What	1 Yes 2 No
h the Ma 3a or 24 otified		Grove Road		21	144		U.	.S.A.
215-0036 be filed within 72 hours after death with the Maryland mal Hygiewer. hed other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 N	12. Was Decedent E Armed Forces? 1 Yes 2	Ever in U.S. XI, No	 Was Decedent of H If Yes, specify Cuba 			- 14. Race - A White, e	American Indian, Black, etc.
rs after of miner in DV F	3 Widowed 4 Di	vorced if Yes, Give Year or Dates:		1 Yes 2 N		of work done	Specify:	White
6 172 hou an "nati cal Exa	Elementary/Secondary (0-12)			uring most of working life	e. DO NOT use	retired)		,
5-0036 led within 72 hour Hygiene. other than "natu	12 17. Father's Name (First, Middle	e, Last)		Commercia		rícían me (First, Middle, N	l .	ectrical
T 0 = 21 _	Michael P	aul Scanla		Mailing Address (Stre	Ann		Bowers	State 7:- Code
nore, MD 21 *ages 1 and 2 should ent of Health and Me at: If item 27 is ma other traumatic ev	Mr. Michael P.		ther	7881 Walnu	t Grove		evern, MI	21144
Ges I an t of Hea :: If iten		n 3 Removal from Stat	e cremato	Disposition (Name of cory or other place)		Date	20c. Location - Ci	
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.	4 Donation 5 Other Signature of Funeral Service		Atla	ntic Cremat 22. Name and Addres	ory 03	8/05/2011 2nd Aven	Glen ue SW Gl	Burnie, MD Len Burnie, MI
ம் உத்தித் Physician	23a. Part I. Enter the disease, o		1479 ne death. Do not	Singleton enter the mode of dying				
/Medical	failure. List only one cause Immediate Cause (Final disease	a Narcotic		ation				Between Onset and Death
	or condition resulting in death) Sequentially list conditions,	Due to (or as a consect b.	quence of):					
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ecuted and - transit		Due to (or as a consected)	quence of):					
O, be exertised by the	X UNPENDED			per me,g91	8-15-	11 sm	I and Division	
Box 6876 death certificate he attending phy of for use as the	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes, outcome 1 Live birth 4 Pregnant at ti	2	Fetal death 3	Ectopic preg	gnancy	23d. Date of de Month	livery Day Year
Box e death the atter ed for u	1 Yes 2 No 9 Un	known 9 Unknown		Other (Specify)				
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of Vital Records, P.O. ag Physician: The law requires that the the this certificate has been signed by meral director, page 2 should be detach. TO Be Completed by P. D.				_		24a. Was a autops	sy prio	re autopsy findings available r to completion of cause of
Rec : The la ificate h r, page 2		. I	· ••• - • • • • • • • • • • • • • • • •	20 Place	e of Death (Che	perfor 1 Yes		th? Yes 2 No
o ಈ 🖫 🖫 🔁	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	t 2 ER/Out	patient 3 DOA	Othor -		Residence 6 🗸	Other: Scene
on of anding P sth. T: After the funers		28a. Date of Injury (Month, Day, Yea ding fd 7-31-			ury at Work? Yes 2 🗶 No	28d. Describe h	ow injury occurred	
Division o septed or Attending hours after death. meral Director: Aft y filled in by the fune Certification:	2 Accident Inve	id not be	ry - At home, far	m, street, factory, office	building, etc.	28f. Location (S or Town, St	treet and Number of tate) 7881 Wa	or Rural Route Number, City 1nut Grove Rd.
Division of Y To the Hospital or Attending Ph within 24 hours after death. To the Puneral Director: After t completely filled in by the funeral ledical Certification: T	4 Homicide 29a. Certifier 1 Certifying P	rmined (Specify) four			late and place, a	Severn,	Md.	
To the He within 24 To the Fu completely	one) 2 Medical Example 29b. Signature and title of certific	aminer: On the basis of exami and manner stated.	ination and/or in	vestigation, in my opinio		d at the time, date a		to the cause(s) (Month, Day, Year)
		1 M. 12			M.E.		July 31, 2011	
	30. Name and address of person Jack Titus MD. De	who completed cause of deaputy Chief Medical Exa) W. Baltimore Str	eet, Baltimo	re, MD 21223		
State	31. Date filed (Month, Day, Year)	32. Registrar's		arkel		, - : - : - :		
Registra	AUG 0 2 20	III Comme	1. 4.	-				

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AMEND ITEM#195, perffl, 6918, 8/23/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7:08PM **Physician** 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MD N/Amore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 12 F Yrs. June 3,1925 Maine 005-20-2591 Director 86 Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County rel', or Items 23a or 28e-f show Examiner number notified at 1 ☐ Yes 2 No Funeral Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 903 Phylen Court Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White er than "naturel", 3 X Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home N/A Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Importent: If item 27 is marked oth any injury or other treumettic svent ones. Be Hewitt Μ. С. Pennington Ethel Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 312 Georgia Avenue Glen Burnie, MD 21060 Nancy J. Smith (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cem, 08/04/11 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Fungral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 100 Month Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4 Pregnant at time of death page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 No 1 TYes 1 Yes 2 No Hospitel or Attending Physicien: 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 papatient 2 EP/Outpatient 3 DOA 2 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a, Date of Injury 27. Manner of Death Certification: After (Month, Day Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗀 Suicide determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Pay, Year) License number 29b. Signature and title of certifie ဂ္ person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Bu timore 300 1 South Touad istrar's Signature 31. Date filed (Mon State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 24516 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frank R. Tasker Physician/ Month Day Year 10 17 p M Medical 8 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUATE HOSPITAL Center Rosedale Baltimore 8. Date of Birth Sept. 22,1937 **Funeral** Sex 1 ♣M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 217-34-2620 9. Birthplace (State or Foreign Country) MD Days Min. 73 Director Usual Residence of Decedent Show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Middle River Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Glider Drive 21220 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. traumatic event, the Medical Examiner 14. Race - American Indian. Armed Forces? by Black, White, etc. and 2 should be filed within 72 hours after or Health and Mental Hygiene. 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Becton&Dickenson 6th Plater Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Evaiena Salmon** ည Frank Tasker Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
123 Glider Drive Baltimore MD 21220 Carolyn P. Tasker /wife Health a Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rossville MD Page 1 8/5/11 1 Number 2 □ Cremation 3 □ Removal from State Gardens of otralith 4 ☐ Donation 5 ☐ Other (Specify) Balto. Muz Sign oure of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ cardiac pulmonary disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affect death.

24 hours affect death.

Funeral Director Affer this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transi estive heart that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Pneumoni Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Pregnant at time of death Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

To the Fune

completed fi Defining Projection. To the best of my knowledge, death decided at the time, date and place, and due to the cause(s) and manner stated.

Defining Nurse Practioner: To the best of my knowledge, death annulus, all the line, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death annulus, all the line, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of cettifier 29c. License number 29d. Date signed (Month, Day, Year)

RES 0000

FRANKLIN SQUAREHOSPITAL BOHOM 21237

Registrar

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State

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egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mohammed

31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Melvin Tayman, Sr. 1820 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6 corges Prince Hospital Social Security Number If Under 1 Year I If Under 24 Hrs. Birthp... Country) MD Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1XX M 2 □ F Months Hours Min. 220 34 3458 Director 73 April 9 Croom. 1938 Usual Residence of Decedent 28a-f shov 10h County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2XX No Prince George's Upper Marlboro 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10420 Lynn Ric Drive 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 10 Black, White, etc. δ 1 Never Married 2 X Married ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2X☐ No Specify: "natural", White Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking 11th permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Vollie Tayman Eleanor Rae Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Tayman (Wife) 10420 Lynn Ric Drive, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 30. 2011 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Upper Marlboro, MD Thomas Episcopal Church Cemetery 21. Signature of Funeral Service License 22. Name and Address of FacilityLee Funeral Home, Inc 663301d Alexandria 1110155 Ferry Road, Clinton, MD 20735 2/rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors and the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury

Month. Day, Year) 27. Minner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred a discount of the Traction Month, Day, 1 🗌 Natural 5 Pending 12011 1 Yes 24 No 1330 M Investigation Accident unententionals noved 3 Suicide 6 Could not be Pl ce of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 4 🗌 Homicide determined City or Town, State) nome Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 only one) 29b. Signature and title of certifier 29c. License number D28759 Hanover Plus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an 31. Date filed (Month, Day, Year) Registrar's Signature State

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Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland /		rtment of H		Mental Hy	giene Reg. No. 2		24518
	Physicia Medic		Decedent's Name (First, Middle, Last) Toby E. Tessler				2. Date of De Month July	_	2011	3. Time of Death 3:05 P M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County		
	Funeral		908 Larch Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last b		Takoma If Under 1 Year	If Under 24 Hrs		rth	g. Birthp	place (State or Foreign
	Director		_122-26-0387 1 □ M 2 🖾 F 77	Yrs.	Months Days	Hours Min.	Feb 1	9, 1934	New	Jersey
	show	٥	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loca	ation				1	0d. Inside City Limits
	Maryk 28a-f otified	Director	Maryland Montgomery	7	Takoma Pa	ark				1 🏿 Yes 2 □ No
	ith the	ralD	10e. Street and Number		10f. Zip Code	24.2		10g. Citizen of V		
	eath w	Funeral	908 Larch Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar		pecify Yes or No-	United	e - America	
36	1 and 2 should be filed within 72 hours after death with the Maryland the Bath and Mental Hygiene. It health and Mental Hygiene. It has the and the trans "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ठ	Armed Forces? 1 ☑ Never Married 2 ☐ Married If Yes, Give		Yes, specify Cubar □ Yes 2 😿 No		to Rican, etc.)	Blac Specify:	k, White, e	
21215-0036	hours natura ical Ex	Completed	3 Widowed 4 Divorced Par or Dates. 15. Decedent's Education 16		ent's Usual Occupa			16b. Kind of Bu	MIIT	
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Maryland	should be filed n and Mental Hy 7 is marked oth raumatic event	0	Leo Joseph Tessler			Dorale	, ,	, iviaiden sumame	,	
lary	should and \int is ma rauma		19a. Informant's Name/Relationship (Type, Print)	9b. Mailing	Address (Street a	nd Number or Ru	ural Route Numbe	er, City or Town, S	tate, Zip C	Code)
e,	and 2 Health tem 27 ther tr		Naomi B. Sloan / Sister 20a. Method of Disposition		Box 630	Bellevi	e, ID 83	3313 20c. Location -	City or To	uun Ctata
mor	Page 1 nent of ant: If it ury or o		1 Burial 2 X Cremation 3 Removal from State ceme	etery, crema	atory or other place	4	'2/2011		•	Maryland
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other tonce.		y pylot C							784 e, MD 21029
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
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	n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):					\neg	
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3876	ath certificate be executed attending physician and for use as the burial-transit	/Med	IF FEMALE:							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	eath 3 🔲 i	Ectopic pregnancy Other (specify)	/		23d. Dat	te of delive	ery Day Year
O.	that th ned by e detac	y Ph	Part II. Other significant conditions contributing to death but not resulting	g in the und	derlying cause give	en in Part I.	23e. Did t	obacco use contr	ibute to th	ne cause of death?
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<u>~</u>	an: The tificate tor, pay		25. Was case referred to medical		26. Pla	ce of Death (Che	1 🗆 Yes	2 🔀 No. 1	I ☐ Yes	2 🗆 No
<u> </u>	hysici his cer Il direc	욘	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/0		Other	· ·		dence 6 🗆 Othe	r (Specify))
on of	nding Path. r: After te funera	Certificate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year)	o. Time of injury	28c. Injury work? M 1 🗆 \		28d. Describe	how injury occurre	ed	
Division of Vital Records, P.O.	al or Atters as after de		3 Usuicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (City or Tox	Street and Numbe wn, State)	r or Rural	Route Number,
	he Hospri in 24 hour he Funera ipleted filla	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 1 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one)	d/or investig	ation, in my opinior	n, death occurred	at the time, date a	and place, and due	to the cau	use(s) and manner stated.
	North To t		29b. Signature and title of certifier		29c. License			29d. Date signed		
			30. Name and address of person who completed cause of death (Item 23a	(Type Pri	D37	142		July 3	1, 20	דות
			G. Coleman 1355 Piccard Drive Ro			20850				
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 2 2011 32. Re Smart's Signature	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ AKOVICH Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Somerford Place of Columbia Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country) 8. Date of Birth 1 M 2 XF Months Min. 219 28 1209 Hours 93 Director 09707/1917 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Double Eagle Drive 21090 U.S. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

item 27 is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Louis Lavich Anna Zupancic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, John Takovich / son 9309 Old Line Drive Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If ite Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park 07/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No Yes 2 1 Yes hours after death.
Ineral Director: After this certific
of filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 20 2 XNo Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred **₩**Natural 5 Pending injury 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

DHMH 17 Rev 7/2009

State Registrar Name and address of person

who completed cause of death (Item

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:15 PM Hndrea Juli 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of maryland medical Can university altimos 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** Year 8. Date of Birth 9. Birthplace (State or Foreign 219-98-5653 1 M 2 D Days Feb. 7, 1967 Country) **Director** MD Usual Residence of Decedent or 28a-f show 10b. County 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Harford Joppa 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Watertons Way or items 23a 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: "natural", 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) FranklinSquare 4yrs RNBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, nd Mental I Milton E. Graf Rose MArie Horstead and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
313 Watertons Way Joppa Maryland 21085 Page 1 and 2 sh ment of Health a ant: If item 27 is Steve W. Velasco /husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If ii any injury or o 1 X Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 8/1/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Acute Myelos enous Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, it any leading to in model cause. Enter Underlying Examiner (or as a nonsequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 10 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of per 22 South Gre John State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Man	,	artment o <i>tificate o</i>			ntal Hyg	giene	011	24521
		Decedent's Name (First, Middle, Las	t)					. Date of Dea	ıth		3. Time of Death
Physicia Medic		Libby Kaspa	ar Voelker				J	Month Uly	31, Da	2011 Year	
Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Towr	, or Location	n of Death		1	. County of De	
		Crofton Care & Rel	nabilitation	n Center		Crofto	on		A	nne Ar	undel
Funeral		5. Social Security Number 6. S	DM 2 VIE	yrs. last birthday) On Yrs.	If Under 1 Ye Months Da		er 24 Hrs. 8 Min.	. Date of Birtl (Month, Day 08-03-	h (<i>Year</i>) _	g. E	Birthplace (State or Foreig Country)
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and show	ē	10a. State 10b. County	10	Oc. City, Town or Lo	cation						10d. Inside City Limits
Maryi 28a-f atifiec	Director	MD Prince G	eorge's		Laurel						1 ☐ Yes 2 🔀 N
a or h	J D	10e. Street and Number			10f. Zip Cod	9	···		10g. Cit	tizen of What	Country?
ns 23 must	Funeral	7700 Cherry Lane				20707			Uni	ted St	ates
r dear		11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 \(\sum \) Yes 2 \(\sum \) No		Was Decedent of Yes, specify C	f Hispanic O ıban, Mexica	rigin? (Specify an, Puerto Ric	Yes or No- an, etc.)		14. Race - Ar Black, Wh	merican Indian, hite, etc.
ge 1 and 2 should be filed within 72 hours after death with the Maryland vt of Health and Mental Hygiene. If item Z7 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates.		∣ ☐ Yes 2 🛣	No Specif	fy:			Specify:	White
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than than 27 is trau		19a. Informant's Name/Relationship (T)			ng Address (Stre				-		
permit. Page 1 and 3 Department of Healt Important: If item 2 any Injury or other		Jeanne E. Latham 20a. Method of Disposition		20b. Place of Dispo		Lakes	Drive				Maryland 21 or Town, State
rage 1 nent of ant: If it ury or o		1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crer	natory or other p					,	
Departm Departm Importal any injul	1	21. Signature of Funeral Service Licens		W. Arunde	. Name and Add	ress of Faci	lity _	2011	- 00	denton	, Maryland
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Medical Examiner		resulting in death) Due to (or as a consequence of):									WCCRS
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24 hours after death. 25 hours after death. 16 hours after death. 17 Figure 27 hours after this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregn Other (specify)					23d. Date of o Month	delivery Day Year
been signed by the should be detached		Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	nderlying cause	given in Par	t I.	23e. Did to	bacco u	use contribute	to the cause of death?
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nis ce direc	10	examiner? 1 🗌 Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpatier	t 3 🗆 DOA	ther: 4K	Nursing Home	5 🗌 Resid	ence 6	☐ Other (Sp	ecify)
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after death. Director: After this certification by the funeral director.	Certificate:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, street pecify)	eet, factory, offic	9	28f	. Location (Si City or Town			Rural Route Number,
within 24 hours are to within 24 hours are To the Funeral Direction of	ledical	29a. Certifier 1 X Certifying Phys (Check 2 ☐ Medical Exami	ician: To the best of my	knowledge, death o	occured at the ti	ne, date and	d place, and d	ue to the cau	se(s) an	id manner as s	stated. le cause(s) and manner sta
thin 2	Me	only one) 3 L Certifying Nurs	e Practioner: To the bes	t of my knowledge, o	leath occurred at	the time, dat	te and place, a	ind due to the	cause(s	and manner	as stated.
5 W 6		29b. Signature and title of certifier	Shound	na Mi)	nse number		2	29d. Dat	te signed (Moi	nth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of De Physician/ onth Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Randallstown Baltimore Examiner Hospital Northwest Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 (19/12/64/149) 4.9 Birthplace (State or Foreign Country) MD Funeral 1 🛛 M 2 🗆 F Hours Min. 216-50-3632 Director Usual Residence of Decedent 10c. City, Town or Location Baltimore 10a. State 10b. County with the Maryland notified at 10d. Inside City Limits Director MDBaltimore 28a-f 1 XYes 2 No r items 23a or iner must be n 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 2703 Ashland Ave 21205 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner þ þ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 🗆 Yes 2 🔀 No If Yes, Give Year or Dates. Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Balt Public Schools Janitor 11Yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Jessie Mitchell Irvin Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kim Spencer Daughter 2703 Ashland Ave Baltimore MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Atlantic Crem 7/26/11 Glen Burnie MD 4 Donation 5 Other (Specify) Signatur Annal Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllen PA 7090 Ridge RD Hanover 11onus Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural injury 5 Pending 1 Yes 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 31. Date filed (Month, Day, Year) State AUG 0 2 2011

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10b, 16a per fh g918 8-10-11 vt. State of Maryland / Department of Health and Mental Hygiene 24523 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RILY WILSON 1049 July 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manlana tomac If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Hours 1 X X 2 - F 218-52-9316 61 Yrs. Director 10/09/1949 MD Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Harford Anne Arundel Jessup MD 1 Yes 2 X No 10e. Street and Number 2037 Citrus Avenue 10g. Citizen of What Country? 10f. Zip Code 20794 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian was becedent Ever in U.S.

Armed Forces?

1 ▼Yes 2 □ No Na Y yes, Give 1968 − 72 Y Black, White, etc ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO Superwitsor Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Transportation -Suppervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Annie Lee Mallonee David Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2037 Citrus Avenue, Jessup, MD 20794 19a. Informant's Name/Relationship (Type, Print) Lydia Wilson / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Final Journey Crem. 1 Burial 2Cremation 3 Removal from State 8/4/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as neequence of) disease or condition Medical resulting in death) Examiner WIMDUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and I for use as the burial-transit MONIC Que to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) 30 48782888 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of South WMarc, 32. Registrar's Signature 31. Date filed (Mo h, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24524 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter Edward Weyer, Jr. P 2113 July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F 303-40-1426 Yrs **Director** 70 Indiana Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Anne Arundel Pasadena 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ō must be 23a Funeral 21122 137 Teal Drive USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11, Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 X Married 1 X Yes 2 No
If Yes, Give
Year or Dates. Viet Nam Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Completed 3 - Widowed 4 - Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government 12 US Navy Retired Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mildred Shockley Walter Edward Weyer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 137 Teal Drive, Pasadena, Maryland 21122 Donna L. Weyer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other pla-Atlantic Crematory, LLC 7/30/3011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Fune Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Pasadena, Maryland 21122 3204 Mountain Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ carc 39 wamou disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and -transit Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be to thours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the P only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ingeborg Hermine Whited Day July 26 2011 1:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Brightview Nursing Home Harford If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 216-28-2284 Months Hours 1 □ M 2 😿 F 83 Yrs. Director 08/06/1927 Germany Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director PA York Delta 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Sycamore Trail 17314 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc er than "natural", or the Medical Examin þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 😾 No Specify. White 3 ₩ Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Payroll Clerk permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Heinz Ruby Heidi Muellmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Balser/Daughter 247 Clubhouse Road, Delta, PA 17314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey crem. 7/28/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) come ning Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exam The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending philor attending at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 X No the 9 Unknown q 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💘 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) VVS) We 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 26,2011 D3225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nu va LIS W. MSC Phy. 5 Anr,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

AUG 02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 1:45 PM 30 Edith Stockton Willard July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Day, Yea (Month, Da Days 1 □ M 2 🗶 F Min 86 Yrs Country) Marvland Director 1924 212-20-6880 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Baltimore Monkton ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 16738 York Rd. 21111 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Nidowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ eq John Elliott Mays Sr. Josephine Mitchell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Robin Willard /Son 16750 York Rd. Monkton, MD 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Aug Department o Important: If any injury or once. ò 01 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rebacco Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final Ph. sician/ LUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Year 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URYA Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Vise AJE 24a. Was an . Were autopsy findings available prior to completion of cause of autopsv perform death? 1 🗌 Yes 2 | No Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2-No 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work?
1 \(\subseteq \text{Yes} \) 2 No Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signati 29d. Date signed (Month, Day, Year) cause of death (Item 234) (Type, Print) N. Charles St. Balts. and 2120x 6781

Registrar

State

Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 1tem#20b,c,perfil,6918,879/2011,WS
State of Maryland / Department of Health and Mental Hygiene 0 1 1 24527 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7/27/2011 Shirley Womack 2:16 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3209 Kelox Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min 1 M 2 F Yrs **Director** 214-48-0998 MD Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore must be notified MD NA 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21207 U.S.A. 3209 Kelox Road items and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 'natural", Specify: 3 Widowed 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12)
2th grade College (1-4 or 5+) 10yrs+ State of Maryland Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary E. Garrett George M. Moulden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $P \cdot O \cdot Box \ 18412$, Tucson, $AZ \ 85731$ 19a. Informant's Name/Relationship (Type, Print) f Health a Danielle Womack-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date - Unk 20c. Location - City or Town, State Department of H Important; If ite 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Woodlawn 8/04/2011 nation 5 Other (Specify) Baltimore, re of Funeral Service Licen see King Memorial March F/H West 'n some Shom 21215 4300 Wabash Ave, Baltimore, 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Treated disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 sl autopsy performed certificate Yes 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 1 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29c. License number 29d. Date signed (Month. Day, Year, 4625 W. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. North AJENUS 922 MD 21217 50~

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)
AUG 0 2 2011

NOMACK

32. Registrar's Signature

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	uneral rector		5. Social Security Number 216-38-4858	6. Sex 1 M 2 D F	e (In yrs. I 70	ast birthday) Yrs.	If Under 1 Months	Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi July 1	rth av, Year) B	941		olace (State or i	Foreign
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21215-0036 within 72 hours after death with the Maryland gjene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Was Decede If Yes, specif 1 Yes 2	y Cubai	n, Mexica	an, Puerto I	city Yes or No Rican, etc.)	-		e - Americ k, White,	etc.	
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fary should and Me	is mar		19a. Informant's Name/Relations			19b. Maili	ng Address (Street a			Route Numb		-		Code)	
e, M and 2 s Health	tem 27	-	Delores Wiegand	l Spouse	20h F	1002 Place of Dispo			<u> 4ill</u>		, Abin				nd 21009 own, State	9
3//// Baltimore, permit. Page 1 and	ant: If i		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 0	emetery, crei	natory or oth	ier placi	dn.	8-5-				-	yland	
Baltime permit. Page Department	lmport any inj once,		21. Signatur & Funera Service I	icensee Lecel		- 1	2. Name and			INC	Comas 1					
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Exa	miner	Į.	Sequentially list conditions,	b. —												
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Piller III II			resulting in death) Last	Due to (or as a	a consequ	uence of):										
JOH K 68760 ertificate be	ling physici e as the bu	/Med	IF FEMALE:	1												
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Vital	certificate lirector, pag		25. Was case referred to medical examiner?	Hospital:				Othe	r-	ath (Check	, ,		(T)			
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Division of our after death.	ector: A	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	pation not be ined 28e. Place of Inju			M eet, factory,	1 🗆 '	Yes 2					er or Rurai	Route Numbe	r,
Div Div Hospital or 24 hours after				building, etc			occured at the	ne time	date and	d place and	City or To			er as state	ed.	
the Ho	the Fu	Medical	(Check 2 ☐ Medical E only one) 3 ☐ Certifying	xaminer: On the basis of ex Nurse Practioner: To the	xaminatior	n and/or inves	tigation, in m	y opinioned at the	n, death o time, dat	occurred at	the time, date	and place he cause(s	e, and due s) and ma	e to the ca inner as st	use(s) and mani ated.	ner stated.
€ Mik	2 8		29b. Signature and title of certifier	al f	M	0	29c. I	License	number			29d. Da	te signed	3/-	Day, Year)	
84	1		30. Name and address of person	who completed cause of de	eath (Item	23a) (Type, F	Print)	CIL		() (4) (4) (4)	00 0	,	1		7/	
	State	-	31. Date filed (Month, Day Year)	32. Registr	≸ Sign	arka	11131C	-4/2	SAPLE	ATTES	VII B	560	MIR	, m	C/0!	7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month al 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Prince Hospita Laure reorge's Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 220-70-8125 1 M 2 M Days Hours (Month, Day, Yea 10rch 29 Director Yrs. Usual Residence of Decedent 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at Funeral Director 10d. Inside City Limits 28a-f 1 Stes 2 □ No 10e. Street and Numbe 0 ms 23a or 10g. Citizen of What Country? 170 LLSA 20705 $\sqrt{000}$ items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 5 ρ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced If Yes, Give Specify: 1QCK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygie 27 is marked other r traumatic event, # Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ ernon 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other transfer. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Walder Heartwood 707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place **D**onation 5_ Other (Specify) 6 201 ignatur 22. Name and Address of Facility towell 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Cardio-Respiratory Physician/ disease or condition resulting in death)) Medical Examiner Acute Myocardial Infarction Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Diabetes the burial-transi Mellitus that initiated events resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day the 9 Unknown Unknown ģ signed to d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an Jas autopsy page performed? certificate ! To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital _ 2 🗶 No မ 1 Yes Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

Laurel Regional

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Sukhjit S. Sidhu,

D 46952

Hospital

7300 Van Dusen Rd.

			For State	State of	Maryland / Dep	artment of I rtificate of I		and M		20	11	24530
		-	Registrar 1. Decedent's Name (First, Middle, La	st)		timeate or i	Death		2. Date of Dear	Reg. N& U	1 1	
П	Physicia Medic		Marvin Allen W	,	ZZ				July	28,	2011	3. Time of Death 2:55 A M
	Examin		4a. Facility Name (if not institution, giv			4b. City, Town, c	or Location o	of Death		4c. Count	y of Death	
Name of Street)		College View Nur	sing Home	2	Frederi	.ck			Fred	leric)	ς
	Funeral Director		5. Social Security Number 6. 5		Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birth Month, Day,			place (State or Foreign
	3		Usual Residence of Decedent									
	/land f sho	호	10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits
	Mar 28a- otifie	Director	Maryland Freder	ick		Mt. A	liry					1 🗋 Yes 2 🔀 No
	h the	를 급	10e. Street and Number			10f. Zip Code				10g. Citizen of		•
	ns 23	Funeral	4160 Walnutwood			217	771			United	Stat	tes
	r iter		11. Manital Status	12. Was Decede Armed Force	es?	Was Decedent of H If Yes, specify Cuba	lispanic Oriç an, Mexican	gin? (Spec n, Pu er to F	cify Yes or No- Rican, etc.)		ce - Americ	
36	after al", o xam	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give		1 ☐ Yes 2 🛛 No	Specify:			Specify		
ö	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	ete	15. Decedent's	Year or Date		dent's Usual Occup	nation				WII.	ite
215-0036	an "n Medi	Completed	(Specify only highest g	rade completed)	(Give	kind of work done	during most	t of workin	ng .	16b. Kind of E	ousiness in	dustry
212	within giene er th , the		Elementary/Seconday (0-12)	College (1-4	Owne	r				HVAC		
	al Hy d oth	Be c	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle, N	Maiden Surnam	ne)	
ylaı	ld be Ment arked atic e	၉	Jacob Oliver War	renfeltz			Elt	a La	una Sho	wman		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	ı	ng Address (Street			Route Number,	City or Town,	State, Zip	Code)
	and 2 s Health s tem 27		Patricia D. Warr	enfeltz ,		Walnutwo	ood Ct	. M	t. Airy	, MD 21	1771	
OF	ge 1 a It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 [Removal from St	ate 20b. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	D	ate	20c. Location	- City or To	own, State
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Spec		Final Jour	_					<u>-</u> _	Maryland
Bal	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of uneral Service Licer	- Hell							Box Svill	784 e, MD 21029
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cau	ised the death. Do not entline.	er the mode of dyir	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
, in a	Physician/		Immediate Cause (Final disease or condition	(una C	ancer	-					Onset and Death
	Medical Examiner		resulting in death)	Due to (or	as a consequence of):							
		r.	Sequentially list conditions,	b. —								
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (or	as a consequence of):							
	xecut n and al-trai	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):							
09	ate be executed physician and the burial-transit	dical		1 d								
376	ficate g ph) as the									-1		
k 687	attending p	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy th 2 Fetal death 3 [Ectonic pregnan	614			23d. Da	ate of deliv	rery
Вох	death	sici	in the past 12 months? 1 Yes 2 No		nt at time of death 5	Other (specify)	Су			M	onth	Day Year
P.O.	it the de	Physician/M	9 Unknown				one in Deat I	1	1			
о. С.	res that signed b	Completed by	Part II. Other significant conditions	contributing to dea	in out not resulting in the	underlying cause gi	ven in Part i	I.				he cause of death?
rds	v require been si should	etec										
တ္ထ	The law pate has be	du l							24a. Was a autops	sy		psy findings available empletion of cause of
Ä	iician: The certificate rector, pag		05.14						perfor 1 Yes	2 1 X No	1 Yes	2 🗆 No
lta/	sician: certific rector,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:		Oth	lace of Deat		, , ,			
of Vital Records,	Phys r this eral di	6: 10	27. Manner of De th	1 ☐ Inp	patient 2 ER/Outpatie injury 28b. Time o	nt 3 🗆 DOA	4 X Nu		ne 5 Reside 8d. Describe ho			()
n	tth. : After e funer	cat	Natural 5 Pending 2 Accident Investigation		Day, Year) injury	worl	k? Yes 2 🗍		ou. Describe no	ow injury occur	ieu	
Division	Il or Attendi after death. Director: A d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	pe 28e. Place of	Injury - At home, farm, str	reet, factory, office		2			per or Rura	l Route Number,
Ο̈́	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.			building,	etc. (Specify) t of my knowledge, death	accurred at the time		-1000 000	City or Towr			
	the Hos hin 24 h the Fur Tpleted	Medical	(Check 2 L Medical Exam	niner: On the basis	of examination and/or invest the best of my knowledge,	stigation, in my opini	on, death oc	curred at 1	the time, date an	d place, and du	ue to the ca	use(s) and manner stated.
	Vithi To th		29b. Signature and title of certifier	0	40	29c. Licens				29d. Date signe		
			1 Cuc Hz	rish	MI	De	1180	120		7/2	81:	2011
			30. Name and address of person who	completed cause	of death (Item 23a) (Type,	Print)	1	-1			0.0	3000
			31. Date filed (Month, Day, Year)	MIS	Svar's Signature	HVP	116	der	ic K	MI	di	102
١.	Stat		ALIC 0 9	2011	awar a digitature	200			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 30 Day $201 {\rm T}^{\rm Pai}$ 4:04 Ам Barbara Ann Weldon-Lawrence Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Necitas Assisted Living 8. Date of Birth (Month, Day Year) August 24, 1931 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Days Hours New York Director 102-24-4594 79 Usual Residence of Decedent or items 23a or 28a-f show filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No <u>Maryland</u> Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 87 Eldrid Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) Science Writer of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I Department of Health and Ments Important: If item 27 is marked any injury or other transcome. ဂ္ Estelle Martin Joseph Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11015 Candlelight Lane, Potomac, Maryland 20854 J. Kirby Weldon / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery August 2,2011 Silver Spring, Maryland 21. Signature of Fineral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Sudden Ph sician/ disease or condition resulting in death) Myocardial Infarction Medical Examiner Months Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine 28 a nomedianne of Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Completed <u>Hyperlipidemia</u> 1 \square Yes 2 \square No 3 \square Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an performed' <u>Depression</u> Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Gupta,

Suresh K.

D32332

9801 Georgia Avenue Suite 220, Silver Spring, Maryland 20902

August 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Mar State of Mar Registrar		artment of Heal			2011	24532
	Physicia		Decedent's Name (First, Middle, Last)	FIGM	AN	2	2. Date of Death Month	23. 2011	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) Northwest Hospital		4b. City, Town, or Locat	tion of Death		4c. County of Death Balti	more
	Funeral Director		5. Social Security Number 212-60-7255 6. Sex 1 💢 M 2 ☐ F 7. Age ((In yrs. last birthday) 57 Yrs.	If Under 1 Year If Under 1 Yea		3. Date of Birth	9. Birth Coun	place (State or Foreign try) MD
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Lo				1	10d. Inside City Limits
	th the Mar 3a or 28a t be notifi	Funeral Director	10e. Street and Number 1413 South Carey Street		10f. Zip Code 212	:30	10g	. Citizen of What Cour	1 X Yes 2 No
036	be filed within 72 hours after death with the Maryland sental Hygiene. Red other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S. 13. \	Was Decedent of Hispanion of Hispanion of Yes, specify Cuban, Mexistra of Yes 2 X No Specific No. Specific N		fy Yes or No- can, etc.)	USA 14. Race - Americ Black, White, Specify: Whit	etc.
Baltimore, Maryland 21215-0036	ed within 72 hour Hygiene. other than "natur ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11yrs	(Give i	dent's Usual Occupation kind of work done during O NOT use retired) eral Labor			b. Kind of Business In	
/land		To Be	17. Father's Name (First, Middle, Last) Gerald Weigman		18. N	Nother's Name (Flor	First, Middle, Maid rence S	den Surname) prinkle	
, Man	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Florence Weigman Mother	19b. Mailir	ng Address (Street and Nu 3 South Ca	umber or Rural F arey St	Route Number, Cit Creet Ba	y or Town, State, Zip (altimore	MD 21230
ıltimore	Page nent o ant: If Iny or		20a. Method of Disposition 1	Atlantic	natory or other place) Crem	7/25/	11 G	Lecation - City or To	Le MD
Ba	permit. Departr Imports any inju		23a. Part 1. Enter the disease, or complications that caused the		Name and Address of Formas Allen			e Rd Hand	Approximate
	h sician/ Medical	0 1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ER	DISEA		_		Interval Between Onset and Death
and the	Examiner	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a condition of the condition of th	consequence of):					
	be executed sician and burial-transit	al Examiner	Cause (Disease or linjury that initiated events c.	consequence of):					
<u>.</u>	refullicate by anding physicase as the b	/Medical	IF FEMALE:						
Š	death he atte ed for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	requires that the been signed by the should be detach	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in I	Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
×	ine law re ate has be page 2 sh	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings available mpletion of cause of 2 No
/ital	s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpation	t 2 🗆 ER/Outpatien	Other:	Death (Check or	<i>nly one)</i> e 5 □ Residence	v hos	nice
on of	naing Fin ath. r: After thi e funeral d	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, 1)	28b. Time of	28c. Injury at work? M 1 Yes	280	d. Describe how i	-)
Division	to the nospital or twenting triystician; the lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (r - At home, farm, stre Specify)	eet, factory, office	28	f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	ure nospi nin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best of m 2 Medical Examiner: On the basis of examonly one)	mination and/or invest	tigation, in my opinion, dea	ath occurred at th	e time, date and p	lace, and due to the ca	use(s) and manner stated.
	Note to the contract of the co		29b. Signature and title of certifier	no	29c. License numb	87	2 d	Date signed (Month,	7011
			30. Name and address of person who completed cause of deal that the second seco	y Aris	Asian Bl	lud G	Ten D	PURMIE	21061
	Stat Registra	ır	31. Date filed (Month, Day, Year) AUG 0 2 2011	Signature	Had				
DHM	H 17 Rev 7/20	09	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24533 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 29, Physician/ 2011 6:45 A^{M} Douglas Lee Worthing Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Rockville Montgomery Montgomery Hospice Casey House 8. Date of Birth (Month, Day, Yea January 31, 9. Birthplace (State or Foreign Country)
1933 Wisconsin 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number Funeral 1 【 M 2 □ F Months Davs Hours Director 389-32-3285 78 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City Town or Location at 10a. State the Maryland Director must be notified 1 X Yes 2 □ No Maryland Rockville Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code ö 23a Funeral with United States 20850 Tapiola Court items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 19 If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 X Married 2 □ No 1956 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Estate and Corporate Law Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Ruth Shaw Kenneth Worthing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Tapiola Court, Rockville, Maryland 20850 Miriam K. Worthing/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Montgomery Crematorium, Inc. þ Department of Important: If any injury or once. July 30, 2011 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licen Robert A. Aprin Mrey Funeral Home, Rockville, Inc. Harai) 300 West Montgomery Avenue, Rockville, Maryland 20850 M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day for Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 X No Jas death?
1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital Other: 1 ☐ Yes 2 X No 4 □ Nursing Home 5 □ Residence 6 🗴 Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 XNatural work 5 Pending after death. Director: Aft 1 Yes 2 No Investigation Accident the Suicide Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O LOY

DHMH 17 Rev 7/2009

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman,

AUG 0

M.D.

D37142

6001 Muncaster Mill Road, Rockville, Maryland 20855

July 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 7:45 PM VIan aveneim Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner abeth timor enter N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Months Month, Day, Year) 23 87 Marvland Director 217 22 4353 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Maryland Baltimore N/A 1 X Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 21227 U.S. 3320 Benson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: "natural", Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than "r rraumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Department Store Retail Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Joseph Chapin Page 1 and 2 should be Gladys Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, Maryland 21144 Cheryl Saylor / Daughter 7804 Hale Haven Court item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/29/2011 Baltimore, Maryland Bavview Crematory 4 Donation 5 Other (Specify) 2. Name and Address of Facility 21. Signature of Funeral Service Licenser Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway Approximate Interval Between Onset and Death 23a. In 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final 6051 Physician/ disease or condition resulting in death) Medical difficile colitis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine abet mellit 21 Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 88 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached the Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Memia certificate has autopsy performed? death? 2 No within 24 hours a er decth.

To the Funeral Director: After this certific completed filled by the funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltiniure Warvan Mo 3320 Avenue MIN Benson State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	tate of Maryland		rtment of F		, ,	ene g. N2011	24535
	Physicia		1. Decedent's Name (First, Middle, Last)	L W	off			2. Date of Death Month	Day Year 25 2011	3. Time of Death
-	/Medic Examin		4a. Facility Name (If not institution, give stre		,	4b. City, Town, o	r Location of Death	0017	4c. County of Deat	n
	Funeral		1 L Johns Hopk 5. Social Security Number 6. Sex	ns Hospita 7. Age (In yrs. la	st birthday)	f Under 1 Year	NOTE CITI	8. Date of Birth	N/A 9. Birt	hplace (State or Foreign
н	Director		213-32-6362	_	63 Yrs.	Months Days	Hours Min.	(Month, Day, 01/13/1	Year) Co 1948	MD MD
]	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Ba-f st	Director	MD BALTIMOR	E GL	YNDON					1 ☐ Yes 2 🔯 No
	with the		10e. Street and Number 4605 PROSPECT AVE	NIIE		10f. Zip Code 21136		10	g. Citizen of What Co	untry? USA
	r death	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	. 13. \	Vas Decedent of F	Hispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	rican Indian,
036	be flied within 72 hours after death with the Maryland Na Hygiene. do other than "natural", or items 23a or 28a-f show event, the Modical Evertine of other than 100 flied Evertine of other than 100 flied Evertine of the notified Evertine of the	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 [X]¥es 2 □ No IfYes, Give YearorDates:		□Yes 2 No	Specify:		Specify: WH	ITE
2-0	72 hou	Completed	15. Decedent's Educati (Specify only highest grade co	on impleted)	(Give	lent's Usual Occup	during most of working		6b. Kind of Business/	
2121	within jiene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ C		OO NOT use retire CIAL REAI	a) LESTATE BI	ROKER	REAL 1	ESTATE
nd .		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M		
ıryla I	12 should be fi th and Mental I 7 is marked ot traumatic ever	은	AARON JOSE 19a. Informant's Name/Relationship (Type.		WOLF	a Address (Street	CAROLYN and Number or Rural	Route Number.	ROS City or Town, State, 2	SENBLOOM Zip Code)
≅	trau		CYNTHIA TREADWAY	T I		•			N, MD 211:	•
w,	of H fiter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rem	oval from State ce	metery, cren	sition (Name of natory or other place			0c. Location - City or	
altin	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	BETH			PARK: 07/27 ess of Facility SOL		RANDALLS ON & BROS.	
ñ	an The		Clay 4		1	3900 REIS	STERSTOWN 1	ROAD, PI	KESVILLE,	MD 21208
		e i	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one commediate Cause (Final			G 1 2000	327	respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a con a que		cinor	na			
	Examiner	F.	Sequentially list conditions, b.	Due to (or as a conseque	ence of):					
20410	nd ransit	Examine	Sequentially list conditions, if any, leading to Immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events co	240 10 101 40 4 00110044	01100 017.					
8760,	incate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
٥	certificate nding physises as the l	ledical	d							
Box	death certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnan	death 3 [Ectopic pregnance	су		23d. Date of de Month	livery Day Year
. 3		hysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	atn 5L	Other (specify)				
ds, l	iaw requires mat me or as been signed by the 2 should be detached	þ	Part II. Other significant conditions contrib	uting to death but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did tob 1 ☑ Ye	acco use contribute to s 2 ☐ No 3 ☐ P	the cause of death?
Vital Records,	as been 2 shout	Completed	Pleus al ell	eislan				24a. Was an	24b. Were at	utopsy findings available
T A	ate h	Com						autopsy perform 1 □ Yes 2	prior to death? ☐No 1 ☐ Yes	completion of cause of 2 □ No
	ioning rinysician: th. : After this certification of tuneral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	oital: 1 ☑ Inpatient 2 ☐ E		t 3 DOA Oth	26. Place of Death		nce 6 □Other (Spe	ncify)
C 3	After thi	on:T	27. Manner of Death 1 Natural 5 Pending	·	28b. Time of Injury	28c. Inju Woi	ry at 2		w injury occurred	
Division	a for Attending residually a street death. I Director: After de in by the funers	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homiside determined	28e. Place of Injury - At hon	ne, farm, str]Yes 2□No 2		eet and Number or R	ural Route Number,
בֿ בֿ	ral Dire		4 Tromicide	building, etc. (Specify)				City or Town		
100	of the nospital of Attendi within 24 hours after death. To the Funeral Director. A completely filled in by the fu	edical		an: To the best of my knowOn the basis of examinati and manner stated.						
	withir To th comp	Me	29b. Signature and title of certifier			29c. Licens		29	9d. Date signed (Mon.	th, Day, Year)
			30. Name and address of person who comp	leted cause of death /ltcm	23a) (Time	Print)	-000	(JULY 25	2011
			DHAVAL F	+GHERA	li	00 Nor	th Wolfes	it, Baltin	nore, MD,	21287
	Sta	te ar	31. Date filed (Month, Day, Year) AUG 0 2 2011	32. Registrar's Signati	DE LOVE	1			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011 24536

			_ FOr	rificate of Death	Reg.		
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last) (atherine 2 ellmer - 1		Date of Death	Day Year	3. Time of Death
	Medic Examin	_		4b. City, Town, or Location of Death Columbia	7	4c. County of Death	
	Funeral Director		5. Social Security Number 216-72-2847 6. Sex 1 □ M 2 ☒ F 7. Age (în yrs. last birthday) . 54 Yrs.	If Under 1 Year If Under 24 Hrs. 8.	Date of Birth (Month, Day, Yes 1 / 2 6 / 1	9. Birthp 956	place (State or Foreign try) MD
۰	aryland ia-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Howard	Ellicott (City	1	0d. Inside City Limits 1 XYes 2 ☐ No
	with the M 23a or 28 ust be not	Funeral Dir		10f. Zip Code 21043	10g	. Citizen of What Cour U	ntry? SA
980	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 Never Married 2 X Married 1 Yes 2X No	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica ☐ Yes 2 X No Specify:	Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	thin 72 hou sne. than "natu he Medica	Completed	15. Decedent's Education (Give k (Give k 12) 16a. Decedent's College (1-4 or 5+) 12 2	ent's Usual Occupation ind of work done during most of working b NOT use retired) Accountant	16	b. Kind of Business In Accoun	
land 2	ould be filed wir nd Mental Hygie marked other imatic event, tl	101	17. Father's Name (First, Middle, Last)	19 Methor's Name /Fi	irst, Middle, Maid ephine		
Mary	2 sh Ith ar 27 is 27 is		19a. Informant's Name/Relationship (Type, Print) Regina A. Leakey/ Daughter 493	g Address (Street and Number or Rural Ro 34 Orchard Drive	oute Number, Cir Elli	ty or Town, State, Zip (Cott Cit	y, MD
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		4 Donation 5 Other (Specify)	urney Crem. 7/28/2	2011 V	voodbine, I	MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licenses Dorrota Marshall. 22	Name and Address of Facility Maryland Crema PO Box 1413, B	tion S Baltimo	Services ore, MD 2	1203
	nysician/ Medical Examiner	ier	23a. Par 1 Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Durito (or as a consequency of): Durito (or as a consequency of):				Approximate Interval Between Onset and Death
0	icate be executed g physician and is the burial-transit	Medical Examiner					
. Box 68760	ath certific tttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
ls, P.O.	uires that the dee n signed by the a uld be detached t	by	Fatti. Other significant conditions contributing to death partner resisting in the	nderlying cause given in Part I.		cco use contribute to t	the cause of death?
Division of Vital Records,	The law require cate has been si page 2 should	Completed			24a. Was an autopsy performe 1 \(\sum \text{Yes} 2	prior to co	opsy findings available ompletion of cause of 2 \square No
/ital	/sician: The s certificate director, pag	To Be (25. Was case referred to medical examiner?	26. Place of Death (Check or other: 4 \(\sum \) Nursing Home		ce 6 Other (Special	5)
on of	nding Physath. r: After this ie funeral dii	Certificate: T			d. Describe how	injury occurred	
Divisi	Hospital or Attendi 24 hours after death. Funeral Director: A eted filled in by the fo			l l	City or Town, S		
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, death of the best of my knowledge, or construction or construction of the best of my knowledge, death or construction or constructio	tigation, in my opinion, death occurred at the	e time, date and	place, and due to the c	ause(s) and manner stated.
	To the within the common commo		29b. Signature and title of certifier M.D.	29c. License number DOO 66517	290	d. Date signed (Month)	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Jar Lane Col	umbig	MD	1044
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24537 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29 Day 201 Year Emma Anna Zehl July 0: 25 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Oakcrest Nursing Home Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Min. July 7, 1914 185-01-7268 **Director** Austria 97 Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8830 Walther Blvd. Unit 310 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Ward Clerk Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Department of Health and Ment Important: If item 27 is marken any injury or other Alois Mirakovits Hedwig Recker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Leizear / Daughter 9519 Powderhorn Lane Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Aug^{Date}2, 2011 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. Rosedale, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee Evans Funeral Chapel & Cremation Service-Parkville 8800 Harford Road Parkville, Maryland 21234 baugh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ASCUD disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): ysician a e burial-Physician/Medical phy: the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Cibrillation Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Domentia 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗷 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending injury 1 Yes 2 No Investigation 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - moneo D58646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bos lovered 8800 Ub Ither Parkvilla

DHMH 17 Rev 7/2009

State Registrar

Box 68760

Division of Vital

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan				and Mental Hy	/gien	201	1 24538
			Registrar	141		Cer	tificate of L	Death		Reg. N	201	24330
	Physicia Medi			LIZABO		20,	2 BACK	1	2. Date of D Month VLC L 7	D	ay Yes	3. Time of Death 3. OS A M
	Exami	ner	4a. Facility Name (if not institution, UPPER CHETAPE			NTER	4b. City, Town, or			4	c. County of D	
	Funeral Director		5. Social Security Number 214-12-8582	6. Sex 1 \square M 2 X F	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days			irth a <i>y</i> 192	9. 2 Ma	Birthplace (State or Foreign County) ary Land
1.	land show dat	١	Usual Residence of Decedent 10a. State 10b. County		10a Cib	y, Town or Lo	action					101111111111111111111111111111111111111
	Marylan 28a-fsk otifieds	irecto	Md. E	salto.	100.00		ttingham					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
305	with the 23a or	eral D	10e. Street and Number 9 Haylock Court	Apt.203			10f. Zip Code 21:	236		10g. C	Citizen of What USA	Country?
3	leath items er m	뎚	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V	Vas Decedent of H	spanic Ori	igin? (Specify Yes or No n, Puerto Rican, etc.)	-	14. Race - A	merican Indian,
) 036	ırs after c ıral", or I Examin	Completed by Funeral Director	1 🏋 Never Married 2 □ Marr 3 □ Widowed 4 □ Divorced	16 V Oi		1	Yes, specify Cuba				Black, W Specify:	hite, etc. White
)O(215-0	n 72 hou e. ian "natu Medica	mplet		nt's Education st grade completed) College (1-4	or 5±)	(Give F	ent's Usual Occup ind of work done of NOT use retired)		t of working	16b.	Kind of Busine	ess Industry
72	ygiene ygiene her th	Be Co	12	4		Reges	tered Nu	rse		He	althca	re
/ i j /land	d be filed Mental H arked ot ttic ever	To B	17. Father's Name (First, Middle, L George W. Zorb	,				18. Moth	er's Name (First, Middle Anna J. B			
700 / 29/11 DCO C Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	ì	19a. Informant's Name/Relationsh Charles J. Zor		BRO.		g Address (Street a 2 Hopkin:		er or Rural Route Numb .d Govan		or Town, State,	
D ^r more	Page 1 ar nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from St	tate Ce	emetery, crem	sition (Name of latory or other place Cremator)		Date 7-30-2011	1	-	or Town, State
TD (permit. I Departm Importa any inju		21. Signature of Funeral Service L		1			1	Schimunek d Nottingh	1		-
	•		23a. Part 1. Enter the disease, or	complications that cau	used the death							Approximate
	Physician/ Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	i line.		eac 1					Interval Between Onset and Death
	Examiner	j.	Sequentially list conditions,	Due to (or	as a consequ	ence of):						
ý	uted Id ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or	as a consequ	ence of):						
Mar 60	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or	as a consequ	ence of):						
/ / 376	certificate nding physuse as the	Medi		T						-		1 -
OC Box	death he atte ed for	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregna 9 ☐ Unknov	nt at time of d	ncy I death 3 eath 5	Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day Year
or b	es that the igned by the be detach	by Pł	Part II. Other significant conditio									to the cause of death?
WE	require	eted	ACUTE RENAL		,			,				Probably 4 Unknown
$\frac{198}{20}$ $\frac{20}{20}$ tal Records,	The law cate has page 2 s	Comp	DIAPETES OSTEOARTHR		(J , 11	GANT	DLOCK	Was.	24a. Was auto perf 1 □ Yes	opsy ormed?	prior death	autopsy findings available to completion of cause of 1? Yes 2 ENo
29 ital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:,			26. Pla		th (Check only one)			
\$ E	Phys r this aral dii	e:	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 M Ing 28a. Date of	oatient 2 🗆 I	ER/Outpatient	: 3 ☐ DOA Otrie	4 ∐ Nu	ursing Home 5 Res			pecify)
12 no	Attending ir death. sctor: After by the fune	icate	1 Natural 5 Pending 2 Accident Investig	g (Month,	Day, Year)	injury	work'		1	now mju	iry occurred	
≥ ≥	al or Atte s after de il Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of	Injury - At hor etc. (Specify)		et, factory, office		28f. Location City or To			Rural Route Number,
Σ	ne Hospital	Medical	(Check 2 \(\sumeq\) Medical Ex	caminer: On the basis of	of examination	and/or investi	gation, in my opinio	n, death oc	place, and due to the concurred at the time, date and place, and due to the	and plac	e, and due to the	ne cause(s) and manner stated
	To the within 7 To the comple	ı — r	29b. Signature and title of certifier	1			29c. License	number				inth, Day, Year)
			1.1.1.		٥		02	133	8	JU	LLY.2	9.2011
10			30. Name and address of person w A A Sucario 31. Date filed (Mopth, Day, Year AUG 02					MED	ICAL CEN	TER	. 70	LAIR, JAA
	Stat Registra	e ar	31. Date filed (Month, Day, Year AUG 02	2011 Len	strar's Signat	far	Red					

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryl				d Mental Hy	giene ₂ n		24539
			Registrar 1. Decedent's Name (First, Middle, La.	et)	Cei	rtificate of l	Jeath	2. Date of De	Reg. No.		
	Physicia		Margaret Fern	Zimmerman				Month	Day	Year	3. Time of Death 18:10P M
100	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of D	July eath	28, 20]		10.101
1			Baltimore Washing	gton Medical	Center	Glen H	Burnie				del Co.
	Funeral		5. Social Security Number 6. S 217–26–1710	THE STATE	rs. last birthday) O Yrs.	If Under 1 Year Months Days		Min. (Month, Da	y, Year)	Countr	ace (State or Foreign
	Director		Usual Residence of Decedent	8	O Yrs.			107/20/1	931	Mar	yland
	shov dat	to	10a. State 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits
	Mary 28a-f otifie	Director		rundel Co.	Arnold						1 ☐ Yes XX No
	th the 3a or t be n	alD	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Count	ry?
	ith wii ms 2 must	Funeral	830 Clifton Aver		110 140	210		\(\(\text{O} = \text{if } \text{V} = \text{All}\)			tates
(0	or ite	by Ft	11. Marital Status1 ☐ Never Married2 X Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No		If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		- America k, White, e	
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Whit	e
5-0	2 hou "natu edica	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of	working	16b. Kind of Bu		
121	ithin 7 ene. • than the M	Son	Elementary/Seconday (0-12)	College (1-4 or 5+)	I .	O NOT use retired) omemaker	-		Otan	Home	
d 2	filed wall Hygid of other svent, t	Be	17. Father's Name (First, Middle, Last)		111	Olicharei	18. Mother's	Name (First, Middle,			
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	မ	Norman Mullini	x			Anna	a Mae F	Reinhardt	:	
lan	should and N is ma		19a. Informant's Name/Relationship (7	, ,		ng Address (Street	and Number or	r Rural Route Numbe	r, City or Town, St	ate, Zip Co	ode)
	and 2 thealth tem 27 ther tr		Mr. Jack Zimmerma		000	Clifton A	venue	Arnold,			
Baltimore,	o = =		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State		matory or other plac		Date	20c. Location -	•	
Ħ	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Speci	fy) A		Cremator		/01/2011	Glen Bu		
Ba	permit. Departn Importa any inju		DU 0057					Singleton			emation , MD 21061
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused the d							Approximate
	nysician/		Immediate Cause (Final disease or condition	A s	0109-	tion Bo	nfun			- 1	Interval Between Coset and Death
-	Medical Examiner		resulting in death)	a. Due to (or as a cons	sequence of):		(1,20	17.			3 444)
		er	Sequentially list conditions,	b. Due to (or as a cons	oguera eft					_	
	ed nsit	Examiner	if any, leading to immediate cause Enter Indentying Cause (Disease or iinjury	Due to (or as a cons	sequence oi).						
	execui nn and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
09	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Funeral Director, After this certificate has been signed by the attending physician and attending physician an	dical		d							
387	rtifical ing ph e as th		IF FEMALE:								
Box 687	ath certific attending p	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live Birth 2 1 4 Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	ру		23d. Date Mor	e of deliver	ry Day Year
œ.	he dea y the a	hysid	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 Unknown	ordeath 5	Other (specify)					
P.O.	es that the dee signed by the a I be detached f	Completed by Physician/M	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause gi	ven in Part I.	23e. Did t	obacco use contri	bute to the	e cause of death?
ds,	requires been sign should be	ed t		****				_ 1 🗆	Yes 2 No	3 🗌 Prob	ably 4 DhUnknown
Sor	law rec has bee	plet						24a. Was		Vere autop	sy findings available
Re	The la	Con						perfo	rmed? d	eath?	·
ta	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. P		Check only one)			,
of V	Phys r this ral dir	일 ::	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatier	nt_3 L_I DOA	4 ∟ Nursir	ng Home 5 Resid	dence 6 Othe		
UC.	arth. After funer	icate	1 → Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year) injury	work	Yes 2 □ No	- 1	low injury occurre	· ·	
Division of Vital Records,	r Attendi ter decth rector A by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (\$	Street and Number	r or Rural I	Route Number,
Ö	ital ours affi										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completed filled in by the fu	Medical	(Check 2 L Medical Exam	sician: To the best of my kr iner: On the basis of examina	ation and/or inves	tigation, in my opinie	on, death occur	red at the time, date a	and place, and due	to the caus	se(s) and manner stated.
	Fo the within Fo the comple	Σ	only one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best o	f my knowledge,	death occurred at the		d place, and due to th	e cause(s) and mai 29d. Date signed		
			* All	118	-	107	155	/	July	78	2011
			30. Name and address of person who	completed cause of death (tem 23a) (Type, F	Print	0		-1 1		/ 1
			Juse Glod Carate Co.	e lundo	503	Tosa	tel (J5120, 1	2/6-12/11	m (n	d. L106
	Sta Registra		31. Date filed (Month, Day) Year) AUG 0 2 201	32. Registrar's Sig	T. May						-1

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 24540 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Albert ANTIN July 16, 4:15 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 15205 New Hampshire Avenue Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Dec. 6, 1959 New York 217-80-2400 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Silver Spring 1 🗆 Yes 2 🗖 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20905 15205 New Hampshire Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floria Soifer Joseph Antin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Northwood Terrace, Silver Spring, MD 20902 Joseph Antin, Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Mt. Lebanon Cemetery 07/18/11 1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Adelphi, MD Signature of Fineral Service I โซ๊ฟร์ที่รัสซ์รัษย์ชีพัยพ Funeral Home 20012 254 Carroll St., NW. Washington. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 51 yrs. shock, or heart failure. List only one cause on each line Immediate Cause (Final Tuberous Sclerosis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause Enter Industrying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) 1 L Yes 2 L 9 D Unknown a 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Seizure Disorder 1 Yes 2 No 3 Probably 4 Unknown Mental Retarda 25. Was case referred to medical

Ph sician/ Medical Examiner

Department of Important: If any injury or

Physician/

Medical

Examiner

Funeral

Director

show

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23a

items death

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"natural",

Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I

72 hours after

Baltimore, Maryland 21215-0036

must be notified at

Examiner

Director

Funeral

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Completed

Be

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physician the buria attending p ģ signed t page 2 s cate !

this

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

To the Hospital or Attending

Physician/Medical

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Completed

Be

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Certificate:

Medical

that the death certificate be executed

Division of Vital Records, P.O. Box 68760

ti	on				_	24a. Was an autopsy performed?	prior to com death?	y findings available oletion of cause of
T			26.	Place of Death	(Check or	nly one)		
Ho	ospital: 1	ER/Outpatient	3 DOA	Other: 4 🗌 Nurs	sing Home	5 Residence 6	XOther (Specify)	group home
on	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inj we M 1	jury at ork? □ Yes 2 □ N	- 1	f. Describe how injury	occurred	Trome
be d	28e. Place of Injury - At he building, etc. (Specifi		t, factory, offic	е	281	Location (Street and City or Town, State)	Number or Rural R	oute Number,
nysic	ian: To the best of my know	rledge, death occ	cured at the tir	me, date and pla	ace, and d	lue to the cause(s) and	d manner as stated.	

Certifier (Check only one)	2 🗌	Certifying Phy Medical Exam Certifying Nur	iner: On th	ne basis of
 		of certifier	1	

5 Pending

Investigat 6 Could not

determine

examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3929 Ferrara Dr., Silver Spring, MD

D0012121

July 18, 2011

George Sengstack, MD 31. Date filed (Month, Day, Year) JUL 2 0 201

examiner? 1 **X** Yes 2 \subseteq No.

27. Manner of Death

1) Natural

2 Accident
3 Suicide

☐ Homicide

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24541 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11, 2 Year 2 011 July Physician/ 11:09 p Alai Feyzi Parirokh Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Min. (Month, Day, Year) 1 🗆 M 2 🙀 30, Iran **Director** 1940 231-15-1198 Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 No Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20879 7213 Barcellona Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes : If Yes, Give 2 X No Specify: White 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) Health Care h and Mental Hygien 7 is marked other tl Nurse Be filed 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. injury or other traumatic Masoumeh Jafari <u>Issa Feyzi</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sayed M. Alai - Husband 7213 Barcellona Dr. Gaithersburg, MD 20879 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 16, 2011 | Falls Church, VA National Memorial Park 22. Name and Address of Facility National Funeral Home Signature of Funeral Service Licenses CC0517 7482 Lee Highway Falls Church, VA 22042 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years Pnysician/ una cancer disease or condition resulting in death) Medical Due to (s a consequence of): Examiner 17 days 1915 Sequentially list conditions, Examine Due to for as a consequence of) rany, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury s been signed by the attending physician and should be detached for use as the burialthat initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🕶 No Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🕅 Yes 2 🗌 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy , page 2; certificate has 1 ☐ Yes 2 ☐ No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Yes ER/Outpatient 3 DOA 1 Hnpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Matural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 3 🗆

31. Date filed (Month, Day, Year) JUL 18 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keshishian

29b. Signature and title of certifier

only one)

Daphne

5

23

10811

TUCY

Medical

4901

Registrar's Signature

29c. License number

Center Drive, Rockville, Maryland

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Maryla	-	artment of F tificate of D		Mental Hy	giene Reg. N20	11	24542
	Physicia	n/	1. Decedent's Name (First, Middle						2. Date of Dea	ath		3. Time of Death
	Medic Examin	al	Claudia Y. Al 4a. Facility Name (if not institution,	varez	ımber)		4b. City. Town, or	Location of Death		.8, Day 201	y of Death	9:30 ам
	LAMINI		Holy Cross Hosp	ital			Silver	Spring			ntgome	
	Funeral Director		5. Social Security Number 579–19–3057	6. Sex 1 ☐ M 2 🛣 F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Sept.	$12^{\text{(ear)}}$	g. Birthp Coun	place (State or Foreign E1 Salvador
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits
	Marylar 8a-f sl tiffed	recto	MD P.G.			owie						1 ☐ Yes 2 🖾 No
	ith the l 23a or 2 st be no	Funeral Director	10e. Street and Number 2127 Princess	Ann Cour	t		10f. Zip Code 20716			10g. Citizen of El Sa	What Cour	,
	should be filed within 72 hours after death with the Maryland I and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		11. Marital Status	12. Was De	cedent Ever in orces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
9500-CLZ	urs after tural", o	ted by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	s 2 K No live Dates.		1 ¥ Yes 2 □ No	Specify: Salv	vadorean	Specify	White	
-612	in 72 ho e. nan "nat Medica	Completed	(Specify only highe	T	d) (1-4 or 5+)	(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	king	16b. Kind of E		dustry
12.0	d withi	Be Co	Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, L			Hou	sewife	40. Marthauta Maria	The second of th	Own 1		
Jan	l be file fental l rked o tic eve	ō	Jose Santos Al	,				18. Mother's Nam Bertilia			ie)	
nary	should and for is ma raumat		19a. Informant's Name/Relationsh			I	ng Address (Street a					·
e,	and 2 Health Item 27		Jose Mauricio E 20a. Method of Disposition	Sonilla/H	201	Place of Dispo	Princess	- 1	1	20c. Location		
Baitimore, Maryland	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	m State G	ate of I	natory or other place leaven Cer	netery	Tuly 22 2011		-	lng, MD
g	permit Depar Impor any in		21. Signature of Funeral Service L	icensee	ale		ancis J. O Univer					g,MD 20901
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	t caused the deach line.							Approximate Interval Between Onset and Death
- 4	Medical	ΪÍ	Immediate Cause (Final disease or condition resulting in death)		eminate		t Cancer				-	Onset and Death
	Examiner	er	Sequentially list conditions,	_{b.} Resp	iratory	Arrest	:					
	uted d ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to	o (or as a cons	equence of):					- 1	
	sate be executed physician and the burial-transit	edical Examin	resulting in death) Last	Due to	o (or as a cons	equence of):						
2/00	ficate t g physias the t			d								
BOX DO	ath certi attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Liv	utcome of predefine Birth 2 Feature Feature Feature 1 2 Feature Feat	etal death 3 L	Ectopic pregnand Other (specify)	су			ate of delive	very Day Year
Э	the de by the tached	Physi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 □ Un	known							
S, 7.	ires that signed Id be de	þ	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	inderlying cause giv	ven in Part I.				he cause of death?
Vital Records,	aw requas beer 2 shou	Completed							24a. Was		prior to co	opsy findings available ompletion of cause of
re Le	n: The l ficate h or, page		25. Was case referred to medical					(D. II. (O)	perfo	rmed?	death? 1 Yes	2 🗆 No
VITA	nysicial lis certi directo	To Be	examiner? 1 \(\sum \text{ Yes} 2 \) \(\sum \text{ No} \)	Hospital:	Inpatient 2	☐ ER/Outpatie	Loth	ace of Death (Checer: 4 □ Nursing H	ome 5 Resid	dence 6 🗆 Ott	ner (Specify	y)
n or	nding Pt th. After the funeral		27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	g (Mo	e of injury onth, Day, Year)	28b. Time of injury	work	y at ?? Yes 2 □ No	28d. Describe h	now injury occur	red	
DIVISION	or Atter after des Director in by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At ding, etc. (Spe		eet, factory, office		28f. Location (S City or Tow		per or Rura	N Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death. To thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical					occured at the time					ed. ause(s) and manner stated.
	To the within 2 To the complete	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practione	r: To the best of		death occurred at th	e time, date and pla	ce, and due to th	e cause(s) and n	nanner as st	tated.
				all				7 0 3 Z	47	7.18	3.2	.011
	3		30. Name and address of person values. Nooshin Farr,	MD 150			Print) Road, Si	lver Spri	Lng,MD 2	.0910		
	Sta Registra		31. Date filed (Month, Pay, Year)	2011 32.	Registrar's Sig	nature A.	hares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\mathbf{u}}^{Month}$ 17, 2011 Elizabeth Jane Allen 6:33 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth (Month, Day, May 12, 9. Birthplace (State or Foreign Country) MD **Funeral** 7. Age (In vrs. last birthdav. 1 M 2 X F 214-30-9460 77 **Director** Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD Rockville 1 Yes 2 No Montgomery 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 20852 USA 11520 Patapsco Drive items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify. Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nancy Unknown William Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3287 S. W. Majestic Court, Palm City, FL 34990 Barbara Allen Spicer/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 2 2011 21 Gate of Heaven Cemetery Silver Spring, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Home Inc. lver <u>Spring</u>,MD 20901 23a. Part 1. Diter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Shock Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury that initiated events Sepsis and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the burla Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2X No ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure, Hypotension 1 Yes Completed 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

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DHMH 17 Rev 7/2009

egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Smitha Bhikkaji, MD

31. Date filed (Month JUL Year)

29c. License numbe

D64100

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day July 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20atePortMaryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7/14/2013 Regis Bell 9:36 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday If Under 24 Hrs. 1 M 2 XF Months Hours 8/27/1927 **Director** 83 258-34-8836 Georgia Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Silver Spring Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9101 Second Ave. 20910 United States within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: **Black** 3XXWidowed 4 ☐ Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other th Beautician Cosmetology event, Be Page 1 and 2 should be filed of the filed of Health and Mental Hyy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Thomas traumatic Mary Heggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Point to Point Square Bel Air, Md 21015 Beverly Lowe/niece other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date unk. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or once, Chesapeake Crematory July 25,201 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave. NW Washington, DC 20012 Fyrene 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Persistent Urinary Tract Infection 2 weeks disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Enterovesical Fistula months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of requires that the death certificate be executed **Bladder Cancer** months that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2X No the 1 ☐ Yes 24e detached Division of Vital Records, P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Hypertension, Diabetes Type II, Anemia 1 Tes 2 No 3 Probably 4 Unknown Completed been 24a. Was an Were autopsy findings available prior to completion of cause of Chronic Kidney Disease, CVA this certificate has page 2 autopsy perform Yes 2XXNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X X No 1 Annual Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of injury 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending After (Month, Day, Year) 1X Natural 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Swamsinga Jan D53367 7-15-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan 9801 Georgia Ave. Suite 117 Silver Spring, Md 20902

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien - State Registrar 24545 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 Shirley Barbour A MJean 9:34 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year 03 30 1 1 □ M 2 💢 F Country) Director 579-68-6352 62 1949 DC Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits be notified Yes 2 No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Meric a Examiner must b once. 6415 Eastern Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. If Yes, Give Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Eugene Crosby Smith Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall C. Barbour/Husband Takoma Park, MD 20912 6415 Eastern Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 07/23/2011 Landover,MD Harmony Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 nen 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Days Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Failure Respiratory 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Rheumatoid Artheritis 24a. Was an autopsy performed?

Yes 2 X No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ဥ 1 K Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After X Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1ጂ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of pertifie 2 29c. License number 29d. Date signed (Month, Day, Year) 07/15/2011 D0071149 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD 20910 Sonia Novak, MD 31. Date filed (Month, Day, Year) State **JUL 2** 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 BENJAMIN FRANKLIN 1543 M BANDY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Alabama 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Days Months Min. 422-54-3107 Director July 06. 1942 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11700 Old Columbia Pike, #403 20904 u.s.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give African-American 01. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r National Security College (1-4 or 5+) Elementary/Seconday (0-12) the Auditor Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Franklin Bandy, Sr. Lueginger Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa Jean Bandy - Spouse 11700 Old Columbia Pike, #403, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Parklawn Memorial Pk. 07/22/2011 | Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee AnneManewaker 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Examiner TRACT WINARY INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of law requires that the death certificate be executed URINARY RETENTION Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No ed by the a s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY METERY DISFASE 1 Yes 2 No 3 Probably 4 Unknown PARKINISON'S DIEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Physician: The PENAL TAYLURE 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNo ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifig

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P.O.

Division of Vital Records,

H-CGH 5755 Cedar Lane, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) JUL 2 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occ

MM

urred at the time, date and place, and due to the cause(s) and manner as stated

D0043662

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	aryland	/ Depa	rtment of ⊢ tificate of D	lealth and Death	Mental Hy	giene 20	11	24547
		Decedent's Name (First, Middle, Last	t)					2. Date of De	eath		3. Time of Death
Physic Med		Mary Alida B	ailey					July	ľ, 2	O Î Î	1:10 а.м
Exam	iner	4a. Facility Name (if not institution, give				4b. City, Town, or		h	4c. County	of Death	1
ر -		10500 Rockville 5. Social Security Number 6. Social Security Number 10. Social Security Number		404 e (In yrs. last	hirthdayl	Rockvi.	Lle If Under 24 Hrs	8. Date of Bir	Mont		ry pplace (State or Foreign
Funera Directo			□ M 2 🖾 F	98	Yrs.	Months Days	Hours Min		5,1912	Wes	t Virginia
nd at	٦ ٍ	Usual Residence of Decedent 10a. State 10b. County		10c City T	Town or Loc	ation					10d. Inside City Limits
larylar 3a-fsl iffied	ectc	Md Montgom	erv		kvill						1 X Yes 2 □ No
the N or 28		10e. Street and Number	CLY	Roc	TO THE	10f. Zip Code			10g. Citizen of	What Cou	untry?
n with 15 23s nust b	Funeral Director	10500 Rockville	Pike Apt.4	404		20852			U.S	. A	
DESILITIOFE, INIGITY ISING Z I Z I 3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates.		If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 🖾 No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ck, White,	ican Indian, , etc. :ite
2 hou	plet	15. Decedent's E (Specify only highest gra				ent's Usual Occupa ind of work done d		rking	16b. Kind of B	usiness Ir	ndustry
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be filed w ental Hygi ked other c event, i	å	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Surnam		IIIICIIC
yiar Id be 1 Menta arked	6	Eugene F. Raphel	•				Julia	Cherbo	nnier		
y Mar nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (T) Mary Anne Shea/N			19b. Mailing 2233 Arli	Address (Street a N. Lexington, Vi	nd Number or Ri ngton St nginia	ral Route Number reet 22205	er, City or Town, S	State, Zip	Code)
Dallimore, bermit. Page 1 and Department of Her mportant: If item any injury or othe		20a. Method of Disposition 1 🛣 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specification 2)		20b. Plac Gari Cer	e of Dispos Letery, orem netery	sition (Name of atory or other place Heaven 7	Ju1	Date y 22, 111	20c. Location -	•	Fown, State
Dentit. Departr Imports any inji		21. Signature of Funeral Service Licens	F M	00215		Name and Addres	s of Facility	DeVol Fu	neral Ho Washing		D.C.20007
Physician	7	23a. Part 1, Enter the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused ne cause on each line.		Do not enter	the mode of dying					Approximate Interval Between Onset and Death Years
Medica Examine	_	resulting in death)	Due to (or as a	consequen	ice of):						2 Years
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oe executician and ourial-real	dical Exa	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):						
cate k	ıω		d							_	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriar-fants.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the live Birth outcomes and the live B	2 🔲 Fetal d	eath 3 🗌	Ectopic pregnancy Other (specify)	<i>y</i>			te of deliventh	very Day Year
ires that t signed b	2	Part II. Other significant conditions co				derlying cause give	en in Part I.				the cause of death?
ne faw requer has been age 2 shou	Completed								psy ormed?	prior to co death?	opsy findings available ompletion of cause of
an: The	Be	25. Was case referred to medical				26. Pla	ce of Death (Che	1 Yes	2.K. No	1 L Yes	2 □ No
hysici hysici his ce I direc	일	Yes 2 El No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER	l/Outpatient	3 DOA Othe	r: 4 □ Nursing I	Home 5 K Resid	dence 6 Oth	er (Specit	5y)
ending P sath. or: After the	Certificate:	27. Manner of Death 1 🖾 Natural 5 🗌 Pending 2 🔲 Accident Investigation		y Year) 28	b. Time of injury	28c. Injury work? M 1 🗆 `	at Yes 2 No	28d. Describe	now injury occurr	ed	
tal or Att		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home . (Specify)	e, farm, stree	et, factory, office		28f. Location (\$ City or Tov	Street and Numb vn, State)	er or Rura	al Route Number,
the Hospi iin 24 hou the Funer apleted fill	Medical	(Check 2 Medical Exami	sician: To the best of n ner: On the basis of ex- se Practioner: To the b	amination ar	nd/or investig	gation, in my opinior	n, death occurred	at the time, date a	and place, and du	e to the ca	ause(s) and manner stated.
12 12		29b. Signature and title of certifier	maden	MA		29c. License	number 37678		29d. Date signed July 18		
		30. Name and aduless of person who of James F. Mackin				int) n Ave. #6	75, Che	y Chase			
St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2 0 201	32 Registrar	r's Signature	for	N.S.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#20b, perFH, G918, 8/8/2011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12, 2011 Robert 1:55 P Berger June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery

9. Birthplace (State or Foreign Country) Hebrew Home of Greater Washington Rockville If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1**X** M 2□ F Director 88 09/19/1922 Pennsylvania 556-28-4510 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1K Yes 2 No Director MDMontgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 6121 Montrose Rd. 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 104.2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 No 1942 − If Yes, Give Year or Dates: 1945 Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Purchasing Agent U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Reba Greenfield Morris Berger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12505 Park Potomac Ave. 6th F1. Potomac, MD 20854 ace of Disposition (Name of Date 20c. Location - City or Town, State Sandy Baron Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-16-2011 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD MO1477 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc. 21. Signature of Funeral Service Licenses 1091 Rockville Pike Rockville, MD 20852 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final Physician Advanced Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and is the burial-true Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No nerai Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064871 6-13-2011 Furli, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 6121 20352 Mina Fazli, Montrose MD 82. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 11:00p Tulv 10 2011 Beatrice Schwartz Barsky Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center <u>Rockville</u> Montgomery If Under 1 Year 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours New Jersey 141-03-2576 Director 90 2/4/1920 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Rockville MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 299 Hurley Ave. 20850 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. . or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 ₩ Widowed 4 Divorced Completed Year or Dates. White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Joseph Schwartz</u> Tillie Warach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ann Strauss-Daughter 5208 White Flint Dr. Kensington, Md. 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) <u>Lebanon Cemetery 7/14</u> Adelphi, 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Funeral Direction Edward Sagel 12/12 MOO910 20850 Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-tr nsi or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Pregnant at time of death 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be Failure to Thrive 2 No 3 Probably 4 Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Pneumonia performed' death? within 24 hours after death.

To the Funeral Director: After this certificate to prompleted filled in by the funeral director, page 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No ٩ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one)

State Registrar

29b. Signatur

31. Date filed (M

and title of certifier

ia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kariva

JUL 18 2011

299

Ave

Rockville. Md.

Hurley

29d. Date signed (Month, Day, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene A. A. A.

			1 - State of Maryland / De State of Maryland / De Co	oartment of Health and N ertificate of Death	vientai Hyç ı	Reg. No. 2011	24550
	Physicia		1. Decedent's Name (First, Middle, Last) Katie Louise Price Brown		2. Date of Dea Month	oth 07/16/2011	3. Time of Death 8:45 pM
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dea	th
	Funeral		Assisted Living at Yellow Bank 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Dunkirk if Under 1 Year If Under 24 Hrs.	8. Date of Birtl	Calv	thplace (State or Foreign
Ų,	Director		056-24-3624	Months Days Hours Min.	(Month, Day 06/16/	1920 Co	NC
	yland f show ed at	ctor	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1 ☐ Yes 2 No
	the Mar or 28a	Dire	VA Hampton City Ham 10e. Street and Number	10f. Zip Code	· I	10g. Citizen of What Co	
	h with t ns 23a nust be	Funeral Director	1107 Aberdeen Road	23666		U.S.A.	
030	filed within 72 hours after death with the Maryland Hygiene. Hygiene ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ ★No 1f Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	
0-CL	72 hou "natu Iedical	Completed	(Specify only highest grade completed) (Given	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business	Industry
717	within rgiene. ner tha t, the N		Elementary/Seconday (0-12) College (1-4 or 5+)	cher		Public Sch	ools
land	ould be filed nd Mental Hy marked oth matic even:	To Be	17. Father's Name (First, Middle, Last) Irvin Price	18. Mother's Nam Eliza		Maiden Surname)	
_	sh ar har 7 is trau			illing Address (Street and Number or Run 46 Palisades Drive			,
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🛣 Removal from State 20b. Place of Discemetery, co	position (Name of rematory or other place)	Date 3/2011	20c. Location - City or Hampton, V	Town, State
Saltin	ermit. Pa Separtme mportan ny injuri nce.			22. Name and Address of Facility Le 8200 Jennifer Lane			
_	BD = 8 0	9	23a. Part 1. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
Ŧ	nysician/ Medical	765	Immediate Cause (Final disease or condition resulting in death)	Hypertipiconio	lis eas-	e	Onset and Death
rengt.	Examiner	L	Sequentially list conditions, b.	Hypertension			
	red nsit	Examiner	Cause Disease or injury	LyperCipidenio			
	e execur cian and vunal-tra	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	JF -		-	
2/60	ficate b g physiass the b	dedical	d				
Box pg	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	elivery Day Year
ν, Ο	res that the signed by a be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute to	o the cause of death?
or vital Records,	aw requi as been 2 should	Completed			24a. Was a	sv prior to	utopsy findings available completion of cause of
He He	n: The I ficate h or, page		25. Was case referred to medical	26. Place of Death (Chec	1 Yes	rmed? death?	s 2 No
VITA	hysicia nis cert I directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			ence 6X Other Spec	ted _{Living}
n or	nding Plath.: After the funeral		27. Manner of Death Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury		28d. Describe h	ow injury occurred	
UIVISION	l or Atter after dea Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Run, State)	ıral Route Number,
-1	Hospita 24 hours Funeral eted filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat of the control of th	estigation, in my opinion, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the within To the	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
			30. Name and address of person who completed cause of death (Item 23a) (Type	D0060638		7/18/11	
dR	w 12		UN WASSITAL ROAD # 310 P	RINCE FREDERI	CK M	D 20678	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) 32. Registra's Signature	pare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 2455 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ D2011 JULY 5 MARY BUTLER 3:45p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FAIRFIELD NURSING CENTER CROWNSVILLE Anne Arundel Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Months Days Hours Min 1 1-8-1924 Maryland **Director** 217-52-2691 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Annapolis 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 130 Hearne Rd. Apt 509 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or i Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Black 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pernit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 9th 0 Domestic Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Chapman Sr Helen Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Jones(Daughter) 203 Miles River Ct. Odenton, Md. 21113 Baltimore, 20a. Method of Disposition 20b. Page to morph (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 7-13-11 Davidsonville, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM REESE AND SONS MORTUARY 1922 Forest Dr. Annapolis, Lavor 21401 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition Medical resulting in death) Due to (or as a conseque Examiner angrene Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Ducito (or as a consequence or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death ☐ Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 X No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Ave

Registrar DHMH 17 Rev 7/2009

State

Kichar

31. Date filed (Month, Day, Year)

JUL

240

32. Registrar's Signature

MD

15 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24552 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Edward Anthony Corboy Physician/ ^{Day} 2011 4:50 A. M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day Year) 17, 1923 Days Hours 1 X M 2 🗆 F 022-18-4507 87 Massachusetts Director Auq. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 28a-f Silver Spring 1 X Yes 2 No MD Montgomery 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 3158 Gracefield Road 20904 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. þ "natural", or 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1943–1946 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. s marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) U.S.government Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 James Joseph Corboy Gertrude Vivian Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. 3158 Gracefield Road, Silver Spring, MD20904 Joan Elizabeth Corboy/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 14 2011 cemetery, crematory or other place)
Georgetown University 1
Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of uneral Service License /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or se a consecuen Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 1 No g Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed' death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Hesidence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

3110 GRACEFIELD ROAD SILVERSPRING, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOVEEN J. PUTHUMANA

059524

July

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Day 2011 Cohen 16 Joseph 11:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Rockvil</u>le Hebrew Home <u>Montgomery</u> 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 1 🔀 M 2 🗆 F 82 Yrs. Director 053-22-7801 1929New 06/ Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No MD Rockville <u>Montgomery</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4857 Sweetbirch 20853 Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ NKorean
If Yes, Give
Year or Dates. War Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "naturaf", Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Buyer Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ Max Cohen Hecht Yetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Cohen / Son MD 20853 4857 Sweetbirch Dr. Rockville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State National MO1477 4 ☐ Donation 5 ☐ Other (Specify) Crematory07/18/2011 Falls Church, VA al Crematory, J. J. Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee Blake Kurt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one muse on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on) Due to (or as a consequence of): resulting in death) Last burialthe attending physician Physician/Medical as the b COHEN IF FEMALE: asn yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No detached for Month Day Year Pregnant at time of death 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify, 2 2 40 မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this npleted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License numbe 0 completed cause of death (Item 23a) (Type, Print)

State Registrar 2. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na	me/Relations		e, Print)			19b. Mailir	g Addres	_					er, City o	r Town, S	tate, Zip	Code)	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical		Certifying Medical E	xamine	r: On the ba	sis of e	xamination		igation, In	my opinio	on, death	occurred a	at the ti	me, date a	and place	e, and due	e to the ca	ause(s) and	manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amand #12pfh7/27/2011 ccdohrb Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician/ 1 7 Day 20^{Year}1 Joseph Allen Carroll 18:58 [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) MD 1 🛛 M 2 🗆 F 0872871944 Yrs. Director 66 218 38_ 5701 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Ridge St. Mary's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20680 Seaside View Road 48851 12. Was Decedent Ever in $\Psi.9.67$ Armed Forces?
12. Yes 2 \(\) No \(\) 1 9 6 4 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black If Yes, Give If Yes, Give Year or Dates. 1966-1969 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12th Government Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mary Victoria Butler ൧ William Francis Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48851 Seaside View Rd.Ridge, MD 20680 19a. Informant's Name/Relationship (Type, Print) Mary Carroll/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/25/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service License 2294 Old Washington Rd.Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between iset and Death Immediate Cause (Final Candio. Ph sician/ Koep walom disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Duri to (Sea a gunsectionne aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No After this certificate Vital within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) o 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Division ☐ Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holl MD 37 proor 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JUL 20** Registrar

ARROLL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 24556

State of Maryland / Department of Health and Mental Hygiene David Theodore Collins Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 19, 2011 2215 hrs **Medical Examiner** David Theodore Collins c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown 211 West Side Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sex **Funeral** Min Months Davs Hours Country) Director 283-46-5458 1 X M 2 F 58 30 Aug. Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location any 10b County 10a State 1 X Yes 2 No "natural", or items 23a or 28a-f show | Examiner must be notified at once. Hagerstown MD Washington imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
It item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 211 West Side Ave. Apt. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 2 X Married Never Married 1 Yes Yes 2 X No specify Specify: White Yes, Give Yea 3 Widowed Divorced 4 δ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Residential 12 th Electrician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norma Jean Reid Bobby Lee Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma J. Collins / Mother MD 21742 16807 Petmar Circle, Hagerstown, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Itimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from Stat Smithsburg Crematorim 07/21/2011 Smithsburg, MD Department of Important: Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gerald N. Minnich Funeral Home Hagerstown, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death (Madical a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed gug hysician/Medical UNPENDED AMENDED ending physician use as the burial -Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE 23b. Was decedent pregnant in the Month Dav Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown is been signed by the should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 V No 3 Probably 4 Unknown þ Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? certificate has page 2 2 No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes ဥ 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot self FOUND: 1 Natural Yes 2 V No Division 24 hours after death. Pending Jul 19, 2011 2200 hrs 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City Could not be 3 🗹 Suicide or Town, State) 211 West Side Avenue, Hagerstown, MD determined within 24 hours a To the Funeral I (Specify) Single Family Home 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 20, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD

Registrar

OCME

gistrar's Signature

Z

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 17 20PF 8:20 A Loren Valentine Clarke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Examiner Charlotte Hall Charlotte Hall Veterans Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 94 Months Davs Hours Min. Feb 14 1917 Washington DC 578-09-5902 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ä 10c City Town or Location death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified Calvert St. Leonard Maryland 1 4 1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 20685 1517 Avenue D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: white If Yes, Give WIII Year or Dates. Specify: "natural", Completed 3 ₺ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) wholesales lumber sales 12 1umberman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Rebecca Padgett Dennis Francis Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Randall - daughter 1517 Avenue D St. Leonard, MD 20685 20a. Method of Disposition July 19 2011 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolicanto Puneral a Service Alexandria Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ARDIAC Medical ue to (or as a consequence of): Examine ARDIOMYMPATA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): MYPERTENSION Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or liniury ESSENTIAL and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 s has performed? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 NO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours a er death Funeral Director A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Letifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the Hosp within 24 hou To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of fertifier 29d. Date signed (Month, Day, Year) 0067788 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte Hall, MD 20622 CEENA RAO 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State of Ma	aryland	-	irtment of Health and tificate of Death		giene Reg. No	2011	24558
Physicia	n/	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Vear	3. Time of Death
Medic Examin	al	Danti L. Crupi 4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or Location of Dea	ith		2011 County of Death	5:15 [™]
/ Examini	er	Montgomery Ger		nita	7	Olney			ontgor	
Funeral Director		5. Social Security Number 6. Se		(Ir yrs. last 62	birthday) Yrs.	If Under 1 Year		^h 1 ^Y 949	9. Birth Cou	nplace (State or Foreign ntry). D.C.
nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	ation				10d. Inside City Limits
Maryla 28a-f s otified	rect	MD Montgom	ery		Rock	ville				1 Tes 2 No
with the 23a or st be n	Funeral Director	10e. Street and Number 4010 Blackpool	Road			10f. Zip Code 20853		10g. Citiz	zen of What Cou A	untry?
death items	Fű	11. Marital Status	12. Was Decedent E		13. V	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	1	4. Race - Amer Black, White	
rs after Iral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 █ If Yes, Give Year or Dates.	No	1	Yes 2 No Specify:		S	Specify:Whit	
72 hou in "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give A	ent's Usual Occupation ind of work done during most of wo DNOT use retired)	orking	16b. Kir	nd of Business I	ndustry
within /giene. ner tha t, the I	ပ္ပို	Elementary/Seconday (0-12)	College (1-4 or 5	+)	Sho	e Salesman				t. Store
d be filed dental Hy irked oth tic even	To Be	17. Father's Name (First, Middle, Last) Onofrio Crupi					ame (First, Middle, a Vassal]		urname)	
2 should Ith and N 27 is ma r trauma		19a. Informant's Name/Relationship (Ty Elisa Crupi/Siste				g Address (Street and Number or F Blackpool Road,				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 KBurial 2 Cremation 3	Removal from State	cem	netery, crem	sition (Name of latory or other place) eaven Cemetery	July 22		cation - City or	
permit. Pa Departmer Important any injury once.		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service License)		Gate	22 F	Name and Address of Facility	ns Funera	1 Ho	er Spri me Inc.	
⊕		23a. Part 1. Enter the disease, or comp	olications that caused	the death. [O University Blv			r Sprin	g, MD 20901 Approximate
Physician/		shock, or heårt failure. List only o Immediate Cause (Final	ne cause on each line		ino	,	,			Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	a. Due to (or as a			1000				<u> </u>
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequen	nce of):					
ecuted and I-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequen	nce of):					
s be exe ysician e burial	_	resulting in death) cast	d							
rtificate ing phy e as the	/Med	IF FEMALE:								
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal d	death 3 🗀	Ectopic pregnancy Other (specify)	<u>.</u>	2	23d. Date of del Month	ivery Day Year
hat the led by t detack	by Phy	Part II Other significant conditions of	ontributing to death b	ut not resulti	ing in the u	nderlying cause given in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
quires t	ted b	Acute re	nal ter	lura	e		_ 1 🗆	Yes 2	□ No 3 □ Pr	obably 4 Unknown
e law rec e has bee ge 2 sho	Completed	Malnut	rition				24a. Was auto perfo	psy ormed?	prior to death?	opsy findings available completion of cause of
ian: Th	Be Co	25. Was case referred to medical				26. Place of Death (Ch	1 L Yes	2 No	i	2 No
hysici his ce I direc	To E	1 L Yes 2 No					Home 5 Resi			fy)
nding Path. r: After tl e funera	icate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Ďate of inju (Month, Day		8b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe l	now injury	occurred	
al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc		e, farm, stre	eet, factory, office	28f. Location (City or Tov		l Number or Rui	al Route Number,
Hospita 24 hours Funeral eted filler	Medical	(Check 2 Medical Exami	ner: On the basis of e	camination a	nd/or invest	occured at the time, date and place igation, in my opinion, death occurre leath occurred at the time, date and	d at the time, date a	and place,	and due to the	cause(s) and manner stated.
To the within To the compl	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	or ractioner: to the	Jose Of HIS KI	o.riouge, C	29c. License number			e signed (Month	
		M-A. Ma				D 00713	314	7	118/20	11
5		30. Name and address of person who o	completed cause of d	eath (Item 23 Prin	3a) (Type, F ce Ph	rint) ilip Drive, Olne	ey, MD 20	832		

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, 30 Cea 2 0 2011

parke

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month July Day Richard Leroy Conn, 17 2011 10:09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Birthplace Country) PA 1 XM 2 ☐ F Hours May 5, Day, Year)43 68 Director 251-74-7166 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r ö Funeral 10604 Ordway Drive 20901 USA Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.

Fant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 🏞 No Specify: White If Yes, Give Year or Dates. 1961–64 Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Secret Service Management Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Anderson Richard Leroy Conn, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Conn/Wife 10604 Ordway Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) July 1 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2011 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Examine if any leading to it made cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a nonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension and the burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the : Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 XYes 2 🗌 No 1 Inpatient 2 KER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month JUL Yaz) 0 2011

12+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel K. Sherk, MD 1500 Forest Glen Road, Silver Spring, MD 20910

egistrar's Signature

D67355

July 17, 2011

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible. amend 34a, b Per PHY & 19b Per PH 6919 9/30/2011 Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item State #2,7/16/2011, per physician, Certificate of Death D. H. WCHD Reg. N2 0 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7/16/2011 Physician/ 74977/201 7:30 AM Glenn Edgar Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ocean City Berlin Worcester 47 Anchor Way Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** MD mtry) 1 X M 2 🗆 F Months Hours Min 8 19 19 19 4 9 ar 220-48-4683 6 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 1X☐ Yes 2☐ No Ocean City MD Worcester Berlin 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be r Funeral 21842 21811 47 Anchor Way Drive USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. 11. Marital Status was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hardware Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Eleanor Mae Lights Edgar George Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add the Streward Nuddellar But Minder, MARNIDANID. 22 1841 Ocean City, MD 21842 Joyce Davis (wife) Anchor Way. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) First State Crematory 7/18/2011 Millsboro DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signaturé of Funeral Seryice Licenses 108 William St. Berlin, MD 21811 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fai enal disease or condition) Medical resulting in death) Due to (or as a consequence of): **Examiner** Diabete Sequentially list conditions, it cany, reading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be or 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 🗌 Nursing Home 5 🗶 Residence 6 🗌 Other (Specify, 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 059847 Atlantic Health Chr. 9714 Healthway D. Berlin My. 21511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Men 55/4

31. Date filed (Month, Day, Year) Arzadon M.D 32. Pagistrar's Signature State 2011

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ EVA GUZMAN DE CRUZ July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TA**K**OMA PARK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 10 1 - M 2 X F Months La Union 1941 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Hyattsville Prince George's 1 Tyres 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Salvador 20783 9004 Riggs RD # 203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify:White 1㎏ Yes 2□ No Specify: Salvadorian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own house Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of pe UNKWNON Toribia Guzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (grand-daughter 8103 Riggs RD Hyattsville, MD 20783 Jaquelin Fuentes Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07/25/2011 La Union Jardines del Golfo 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funeral Services, Inc Signature of Funeral Service Licensee rece 600 Kennedy ST, NW: Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ SEVERE HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ATRIOVENTRICULAR DISRUPTION Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). AORTIC VALVE REPLACEMENT that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No ed by the a detached f 1 L Yes 2 L 9 L Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an perform certificate ! 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed After this certification funeral director, p within 24 hours - fter death.

To the Funeral Cirector Air completed filled in by the fu the

Medical Certificate:

State Registrar

LAKHANPAL, SAN 31. Date filed (Month, Day, Year)

30. Name and address of person who comple

29b. Signature and title of certifier

27. Manner of Death

1 Natural

Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check only one)

> cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE 62. Registrar's Signature

28a. Date of injury (Month, Day, Year)

JIV

5 Pending

Investigation 6 Could not be

determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

TAKOMA PARK, MD 20912

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Linda Ann Evans 2:15 \mathbf{P} M 2011 Ju1y 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Richey Hospice Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 578-64-1558 **Director** Mississippi 61 Feb. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director DC Washington YX Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4911 Jay Street, N.E. 20019 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Internal Revenue life. DO NOT use retired) College (1-4 or 5+) **2years** Elementary/Seconday (0-12) Secretary Service is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Charles James Reed Helen Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Carlton Evans, Jr. - Son 8418 Wagon Wheel Rd., Alexandria, VA 22309 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date National Harmony Memorial Park 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/22/2011 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park
Name and Address of Facility McGuire Funeral Service, In.
Will Wash., D.C. 20012 21. Signature of Funeral Service License 7400 Georgia Ave., N.W., Wash., D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician. The Irw requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Variar signed by the attending physician and deed detached for use as the burial-man Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records. ate has been signaled by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certifi ate i completed filled in by the funeral director pag 2 🗌 No 2 € 1 \square Yes Yes Division of Vital 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tyes 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

71414

-inda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 0 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2.3 per doc g919 9-29-11 vt. State of Maryland / Department of Health and Mental Hygiene 2011

24563 For State Registrar Certificate of Death 2. Date of Peath 1. Decedent's Name (First, Middle, Last) 3. Tone of Theath July 14, 2011 Physician/ 00:42 M Leland Andrew Eastman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 XM 2 🗆 F 04/18/1943 Guyana 68 Director 133-52-1353 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat" any injury or other traumatic averations. 10d, Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Silver Spring MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 Guyana 3423 Castle Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces2 1 ☐ Yes 2 ☐No Black, White, etc. 1 Never Married 2 Married 9 1 ☐ Yes 2 🔼 No Specify. If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Store Clerk Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည Mignon Eastman Cecil Salmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3423 Castle Way Silver Spring, MD 20904 Corina Eastman/Daughter Date unk. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, DC 20012 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physiciar Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for 1 ☐ Yes 2 L g ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Caccident 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No Vascular Panpharod this certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case re-erred to medical Be 26. Place of Death (Check only one) examiner? 2 🗗 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 မ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signatur Addite of certifie person who completed cause of death (Item 23a) (Type, Print) #216. ROCKUTTE, MD 4701 Kando 31. Date (State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	/ Department of Health and Mental Hygie 20		

		For State Registrar		State of I	Maryland	/ Depa	artment <i>tificate</i>	of He	ealth a Death	and Me		gle zi e U Reg. No.		2456) 4
Physicia /Medic		Decedent's Name (F Loui		nia Englebr	echt						Date of De Month July 24	Day	Year	3. Time of 3:45	Death ${f P}^{\sf M}$
Examin	er	4a. Facility Name (If no Coffman Nu	rsing Hom	e, Inc.				Hage	Location o	n	(5)	Was	ty of Death		
Funeral Director		5. Social Security Num 214-10-2516	5	Sex 7. 1 □ M 2 X F	Age (In yrs. las	Yrs.	If Under Months	Days	If Under : Hours	Min.	Date of Bird (Month, Da ovember	th y, Year) 8, 1913	Cou	olace (State of ntry) Land	r Foreigi
Maryland -1 show fed 21	tor	Usual Residence of De 10a. State 10 Maryland	ocedent Ob. County Washing	ton	10c. City, 1	Γown or Lo		erstow	vn.					10d. Inside Cit	
with the	i Direc	10e. Street and Number 17935 Clubb		v e			10f. Zip	Code 217	740			10g. Citizen of		•	ca
pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, It a Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 3 Widowed 4 [12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No		Was Decedif Yes, spec	ify Cuban	spanic Orion, Mexican	gin? (Specif i, Puerto Ric	y Yes or No can, etc.)		ack, White	can Indian, etc. White	
within 72 ho iene. r than "natur	Completed	15 (Specify Elementary/Seconda 12		ducation ade completed) College (1-4d		(Give life. I	dent's Usua kind of wor DO NOT us nt Hous	k done di e retired)	uring most	t of working		16b. Kind of		ducation	1
uld be filed lental Hyg rkad othal lic event,	To Be C	17. Father's Name (Fir									First, Middle,	, Maiden Suma	ime)		
nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name Dorothy Mul	_				-					er, City or Tow			
Pages 1 ar		20a. Method of Dispos 1 ■ Burial 2 □ C 1 □ Donation 5 [Cremation 3 [□Removal from Sta	cerr	etery, cren	sition (Nam natory or ot et Ceme	ther place	9)	Date July 29	9, 2011	20c. Location			
permit. Departr Importe any nit. once.		21. Signature of Fune	ral Service Lice	nsee	M014:	33 I	Name and	d Address Basi Chun	s of Facilit Ford P	A. Fur	eral He	ome ck, Maryl	and 21	701	
Physician /Medical Examiner		23a. Part1. Enter the shock, or heart for Immediate Cause (Fin disease or condition resulting in death)	nal	a. Due to (or	27722	THRI		e of dying	, such as	cardiac or r	espiratory a	rrest,		Approximate Interval Betwoest and E	ween Death
icate be executed physician and s the burial-transit	dical Examiner	Sequentially list condition and leading to immediate. Enter Underly, Cause (Disease or injuthat initiated events resulting in death) Las		Due to (or c. Anu p	as a conseque	Deme	WTH							Yans	
The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 Yes 2 Yes	onths?		2 ☐ Fetal de t at time of deal	eath 3	Ectopic pre						Date of deliv		Y ear
quires thai n signed l uld be det	ed by P	Part II. Other significa	nt conditions	contributing to deat	h but not resulti	ng in the u	nderlying ca	ause give	in in Part I.			tobacco use co Yes 2□No	ntribute to		leath? Jnkno
sician : The law requir certificate has been si irector, page 2 should	Completed										24a. Was auto perfo 1 Yes	an 24b psy prmed? 2D No		opsy findings a completion of ca	
aling Phy I. After this funeral d	ation: To Be	2 Accident	5 🗆 Pending investigatio			VOutpatien Bb. Time of Injury		8c. Injury Work	at 4 Nu	ursing Home		one) idence 6 🗆 C how injury acc		ify)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral.	Certification:	4 Homicide	6 Could not be determined	building,	Injury - At hom etc. (Specify)						City or To				ber,
hou ner y fill	Medical	29a. Certifier 1 (Check only 2 one)	Certifying P Medical Exa	hysician: To the be miner: On the basis and manner	s of examination	edge, death n and/or in	occurred avestigation,	at the time in my op	e, date an inion, dea	nd place, an oth occurred	d due to the at the time,	date and place	e, and due	stated. to the cause(s	i)
in 24 in 24 ine Fu	0											DO 4 D -11-	and (blanch		
within 24 To the Fu	Me	29b. Signature and title	e of certifier HOed	W/	mo		29c	License	number	1				Day, Year)	

DHMH 17 Rev 1/2001

VOID Certificate 2011-24565

SEE Certificate 2011-25046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Edward Faulkner 11:06 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner th lisbury tospice 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) Wash. **Funeral** 97ex 1 1 M 2 □ F 78 Months Hours Min 579-40-6354 **Director** DC 30 - 193Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d, Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director Ocean City 1 Yes 2 No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 13609 Barge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Faulkner þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ₩ No Specify: Specify: Korea Completed 3 Widowed 4 Divorced white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gov. Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Evelyn M. Winkleman James S. Faulkner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13609 Barge Road Ocean City, MD 21842 19a. Informant's Name/Relationship (Type, Print) Joy Erma Faulkner-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 7-19-11 Millsboro, DE First 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MALIGNANT CARCINDUMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Sunto (or es e consequence ci): cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 FNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed After this certificate has been significate has been significated funeral director, page 2 should h 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy performed Yes Z 2/1NO 1 🗌 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2/1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Tyes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1)005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DAI 6+1

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31. Date filed (Month, Day, Year)

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BRP

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 24567 Kenneth Bennett Fischer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Kenneth Bennett Medical Examiner Fischer 0532 hrs July 23, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2211 Hindle Lane Bowie Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Forei Pennsylvania Country Months Days Hours Min. Director 07/06/1955 212-68-0265 1X M 2 F 55 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Bowie MD Prince George's 1 X Yes 2 No "natural", nr items 23a or 28a-f shnw Examiner must be notified at once. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2211 Hindle Lane 20716 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after White it: If item 27 is marked other than "natural", nther traumatic event, the Medical Examiner 3 Widowed 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 N/A 12 Disabled Department of Health and Mental Hygiene. Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Allen W. Fischer Nina Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Allen W. Fischer, II/Brother 2211 Hindle Lane, Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Hillcrest Mem. Gardens 07/29/2011 Annapolis, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause or Between Onset and Medical Death a.Dilated cardiomegaly complicated by Hypothermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) Examine Due to (or as a consequence of): events resulting in death) Last and transit Hospital nr Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g918 8-22-11 sm X UNPENDED e attending physician for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Schizophrenia pleted of Vital Records, has been si 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page After this certificate ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification subject exposed to Division Natural 5 Pending 1 Yes 2 X No 24 hours after death. To the Funeral Director: completely filled in by the fd 7-23-11 fd 5:15 am environmental heat 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State 2211 Hindle Lane.
Bowie, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24568 For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month Physician/ 831 AM M July Ann-Louise Gross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min. Country)
NY 1 □ M 2 💢 F 19[38] Director 089-32-6632 items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County event, the Medical Examiner must be notified at Director 1 √2 Yes 2 □ No Montgomery <u>Silver</u> Spring 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20902 1705 Billman Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ō 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", Completed 3 √Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) $1\ 2$ College (1-4 or 5+) Own Home <u>Homemaker</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Judith Meyers Irving Shotland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 927 Willow Leaf Way Rockville MD 20854 Arnold Tarzy - son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 07/10/11 Olney, MD Mem. Grdns! Judean 22. Name and Address of Facility
Edward Sagel
1091 Rockvi 21. Signature of Funeral Service Licenses Funeral le Pike Inc MD 20852 MOO910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ cardiovascylos tenoscusota) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Dualto (or as a normaquanea ot): if any, leading to immediate cause. Enter Underlying cate has been signed by the attending physician and page 2 should be detached for use as the bunal transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No completed filled in by the funeral Certificate: 27. Manner P Death 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c, License numbe 29d. Date signed (Month, Day, Year) 10

State Registrar Vergeni ettos da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24569 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 5:30 AM 2017 ROSE CELESTE GREAVES Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Olne Hurnital Montgomer Birthplace State or Foreign If Under 1 Year 8. Date of Birth If Under 24 Hrs. **Funeral** 1 □ M 2 🛭 F Months Days Min Hours 10/04/1954 Barbados unk **Director** Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at Director 1 XYes 2 No 28a-f Silve Spring MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Funeral items 23a Barbados 20906 14213 Grand Pre Road, #303 death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 24 No Black, White, etc. "natural", or 1 X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No If Yes, Give Specify: Black 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Barbados Embassy Accountant years Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katnleen Massiah Colin Greaves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1025 Maris Lane, McDonough, GA 30253 John Greaves - brother 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory of other place) Department of H Important: If ite any injury or ot 1 Burial Cremation 3X Removal 4 Don tion 5 Other (Specify) Cross Ch Cem. 07/30/11 St. John, Barbados Funeral Service Licer 22. Name and Address of Facility Snowden Funeral Home Signatur 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death one that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure. List only o Immediate Cause (Final Ph_sician/ howe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner me tustation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury) Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician if for use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Other (specify) 1 Yes 2 Unknown ate has been signed by the a page 2 should be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforr To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accider iniury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar 29b. Signature and title of certifier

Manju Arun Mavanur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

29c. License number

18101 Prince Philip Drive, Olney, MD 20832

D0071314

29d. Date signed (Month, Day, Year)

114/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24570 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 6:00 P M July 16, 2011 Ghazarian Astkhik 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bel-Pre Health & Rehabilitation Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan.6, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 TF Iran 81 216-08-7726 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1⊠Yes 2 No Md. Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 20906 U.S.A. 2104 Carriage Square P1. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tarlan Zaghinian Mardiros Abramian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2225 Cold Meadow Way. Silver Spring, Md. 20906 Rouben Ghazarian (Son) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. July21,2011 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License #670 Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave, Riverdale, Md. 20737 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of)

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

7 is marked other than "nature traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other tra once.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

buria attending physician for use as the burial Be Completed by Physician/Medical signed by the a certificate has been s rector, page 2 should Medical Certification: To this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed 1 □ Yes 2 □	
25. Was case referred to medical		26. Place of Deal	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing He	ome 5 Residence	6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investiga	1	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	
3 Suicide 6 Could no determin		et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	Physician: To the best of my knowledge, death xaminer: On the basis of examination and/or inve- and manner stated.			
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month) Day, Year)

State Registrar 30. Name and address of

05

person who completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Month Year Oscar dical Examiner Armando Garcia 1050 hrs July 10, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1704 Arcola Avenue Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 214-15-3318 Months Days Hours oreign EduntySalvador Director 57 1²M 11/26/1953 2 F Usual Residence of Decedent iny 10a State 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. MD Silver Spring 1 Yes 2 No Montgomery nours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1704 Arcola Avenue 20902 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No El Salvadoran Yes White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify Baltimore, MD 21215-6036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", <u>۾</u> r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jose Luis Garcia Maria Leticia Rodriguez 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maira E.Garcia/Wife 1704 Arcola Avenue Silver Spring, Md20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State crematory or other place) Chesapeake Crem. 7/16/2011 Beltsville, Md 4 Donation 5 Other Specific Phylipped Address of TWALDI FUNERAL SERVICE, P. A. 9241 Columbia Blvd.Silver Spring, Md2091 21. Signature of Funeral Service r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. een Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi certificate be execut Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ Diabetes; Alcohol Abuse 1 Yes 2 No 3 Probably 4 V Unknown pleted 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of certificate has performed? Com ✓ Yes 2 No 1 🗸 Yes After this certific funeral director, p To the Hospital or Attending Physiciao: within 24 hours after death.

To the Funeral Director: After this certifi 25, Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification 1 V Natural Pending 1 Yes 2 No the Investigation 2 Accident completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 뗭 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME July 11, 2011 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21, Day 2011 Year July Ann Graham 11:30P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hillhaven Assisted Lvg Nursing & Rehab Center Adelphi Prince George's If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Hours Min. Aug. 29, 1925 85 208-16-3988 Director Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5012 Mineola Road 20740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72... h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Drug Store Cosmetician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Tupica Sophia Buczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra John Charles Graham -son 5012 Mineola Road College Park, Maryland 20740 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Maryland National Mem. Park 7/26/2011 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bôhaid V. Böfgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complimitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Que to (or aş a conseque ce of) Examiner 414610 vascular cause that y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Cardio ascula Dispasa Exami attending physician and for use as the burial-transit resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown To. in the past 12 months? Month 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Damanta 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed Mandibular Carcinoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hypartunsion 2 🗆 No 2 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 Accident
3 Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier 1 Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c, License number 47867 7/22/2011

Registrar
DHMH 17 Rev 7/2009

State

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2011

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

4701 Randolph Rd # ZIB ROCK VILL, MD, 20852.

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24573 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 15, 2011 5:25 P Julian S.T. Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlotte Hall S. Mary's Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral g. Birthplace (State or Foreign 1 Q M 2 □ F Country)
Washington DC Months Hours (Month, Day, Year) Director 71 <u>579 52 2422</u> Jan 13 1940 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Prince George's Fort Washington 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 20744 912 Palmer Road Apt #9 United States ge 1 and 2 should be filed within 72 hours after death י it of Health and Mental Hygiene. If item 27 is marked other than "natural" אילייייי Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian was Decedent Ever Armed Forces? 1 XXYes 2 \(\text{No}\) If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 Widowed 4 Tirorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mechanic -U.S.A.F. US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Percy B. Hall Doris M. Tucker other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliana M. Hall (Daughter) 912 Palmer Road Apt #9, Fort Washington, MD 20744 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page Department o Important: If any injury or once. ò 4 Donation 5 Other (Specify) Lee Crematory July 22, 2011 Clinton, MD 21. Signature of Funeral Service Licensee MO155 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner of denying Cause (Disease or linjury Examine Due to (or as a consequence of): ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicial the Funeral Director: Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) detached for in the past 12 months? Month 2 No 9 🔲 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ESSENTIAL MYPERTENSION 2 No Completed 1 Yes 3 Probably 4 Unknown DISEASE CORONARY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 25. Was case referred to medical Be 26. Place of Death (Check only one. Hospital: Other: 1 Yes ٩ 2 3 34 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending in 24 hours.

the Funeral Director.

**ed filled in by the for 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one) 29b. Signature and title of certifier 29c. License number D0067788 WD .18.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RSIST RAO EENA KODALI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\operatorname{July}^{\scriptscriptstyle{\mathsf{Month}}}$ 17^{ay} Holly Henry Healy 201^{Yea} 16:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 23341 Whitetail Rd. Smithsburg Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Months Hours 217-56-0585 March Day Year 46 Maryland Director **",1**965 Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland addrent of Heath and Mental Hygiene. addrents If item 27 is marked other than "natural", or items 23a or 28a-f show fortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injuny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Smithsburg 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23341 Whitetail Rd. 21783 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Never Married 2 🕅 Married Black, White, etc. Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes. Give 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dental Hygienist Dentist Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hollis E. Henry Phyllis C. Hook Henry permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Healy-husband 23341 Whitetail Rd. Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ringgold Cemetery 7-22-2011 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ metastatic breast cancer disease or condition zyears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 D 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 2 1 N Yes Division of Vital 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? <u>-</u> Other: 4 🗆 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide within 24 hours after death.

To the Funeral Director: A:
completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 18 2011 D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 747 Northern Ruenue B-WC Hospice of Washington County CYPTRIA Kuther Sands, mo Hagerstown, Mary land 21742 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24575 Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ W. Edward Hair 18 July 20Î1 5:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilchrist Hospice Care Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 🗙 M 2 🗆 F Hours 09/17/1944 **Director** 579 56 3642 66 Usual Residence of Decedent Show or 28a-f sho 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number ō 10g. Citizen of What Country? ms 23a or must be r by Funeral 8740 Cedar Post 21.043 United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 9 Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry aith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Hair Jr. Elizabeth Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Freida G. Hair/Wife 8740 Cedar Post Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Mem. Park 4 Donation 5 Other (Specify) 7-25-2011 Clarksville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. llno 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LEUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PULMONARY HYPERTENSION Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? ATRIAL FIBRILLATION 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMANIMO

Year)

6336

32. Registrar's Signature

D64395

CEDAR LANE

29d. Date signed (Month, Day, Year)

COLUMBIA, MD 21044

JULY 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, 24 Physician/ :50 . Medical 4a. Facility Name (if not institution, give street and number) Town, or Location_of Death 4c. County of Death Examiner Ceci A MANYLAND HEALTH CARE SYSTEM CRRY PINIS 8. Date of Birth (Month, Day, Year) 12/23/1945 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign KNOWN TO PHOSCION; HOLL, JOE PIAN **Funeral** Hours Rhode Island Director 035-28-3696 65 Usual Residence of Decedent or 28a-f shov e notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Davidsonville 1 Yes 2 No Anne Arundel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 3259 Beards Point Road 21035 USA items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 X Divorced Completed Year or Dates. 1965–67 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event the Man Elementary/Secon conday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Marshall Hall Hilda Mary Spence should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3259 Beards Point Rd., Davidsonville, MD 21035 Page 1 and 2 Ann Aguilar/ Friend 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State かとう 7/15/11 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) rvice (censee 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final GAngrun-Physician/ **LINKNOWN** Medical resulting in death) **Examiner** VIAT DISLASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10 29c. License number 4+1 VA MARY LAND HEALTH CALE SUSTEM State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24577 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\mathbf{u}\mathbf{1}\mathbf{y}}^{\mathsf{Month}}$ 13^{Day} Edward P. Hilgenberg 2011 06:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Medical Center Anne Arundel 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In vrs. last birthdav) 1 X M 2 - F Months 10/12/1924 Washington,D.C Director 578-09-8380 86 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and S7 is marked other than "natural", or items 23a or 28a-f show Ther traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** 1 Yes 2 No Maryland Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Samantha Lane, Unit 304 21113 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give
Year or Dates. W.W. II Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Specify Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Records Management Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Stes1 William Hilgenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Hilgenberg/Wife 1007 Samantha Lane, Unit 304, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ot: X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 7/19/11 Crownsville, MD 21. Signature of Funda ^{22. Name and Address of Facility}George P. Kalas Funeral 2973 Solomons Island Road, Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Cowithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached if g Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2[Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes ၉ npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certifie 2 29d. Date signed (Month. Dav. Year) 18/6

State Registrar

10 H

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

Division of Vital

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles . W. Phylon M.D. 135 O/D S

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ LAWRENCE HARRIS 3:45 PM 201 July Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Crownsville Fairfield Nursing Center If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number . Age (In yrs. last birthday) **Funeral** Feb 12 Hours 1 X M 2 □ F ^(ear) 919 Maryland 92 Director 212-16-5488 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21401 1999 Forest Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever in U.S.

Armed Forces?

1

Yes 2 □ No

If Yes, Give

Year or Dates 1944-46 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify **Black** "natural" Completed 3 ₩ Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Union Memorial and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Shipping Clerk 11th Ò other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Carrie Johnson James Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Lawrence L. Harris(Son) 1999 Forest Dr. Annapolis, Md. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 7-18-11 Maryland Veteran : Miname Researce RecilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee Tarry 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ disease or condition n Medical resulting in death) Due to (or as a consequence of) **Examiner** Jament Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the þ d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Artery Disease 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate hompiate and the funeral director, page completed filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 No 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Inpatient 2 I Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

State

1921

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Raymond Alfred Harrington Physician/ July 13 20°1′1 12:15 P M Medical 4a. Facility Name (if not institution, give street and number)
217 N. Linden Avenue 4c. County of Death
Anne Arundel 4b. City, Town wn, or Location of Death Annapolis Examiner . Social Security Number 220–16–7352 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1<u>927</u> Maryland 1 X M 2 □ F Months Days Hours (Month, Day, Ye 83 Aug. Director 28a-f shov 10b. County 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location Director Annapolis Anne Arundel Maryland 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 217 N. Linden Avenue 21401 Funeral U.S.A. 2 should be filed within 72 hours control and Mental Hygiene.
27 is marked other than "natural", or items
27 is marked other than "hatural", or items items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 XXMarried Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give Year or Dates. 1945-46 Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Civil Engineering Land Surveyor Be 18. Mother's Name (First, Middle, Maiden Surname)
Maud Agnes Bright 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1
Department of Health and Mental Important: If item 27 is many injury or othe-ம Raymond A. Harrington, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 217 N. Linden Avenue Annapolis, Maryland Lee Harrington/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Baltimore Crematory 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State 7/19/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Traneral Segli 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prostate Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir nding physician and ise as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ρ Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2XXNo has I or Attending Physician: The after death.
Director: After this certificate b 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural iniurv 5 Pending the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Hospital 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. **XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) R118703 July 15, 2011

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

Genevieve Lightfoot-Taylor

DHMH 17 Rev 7/2009

rack

445 Defense Highway Annapolis, Maryland

of death (Item 23a) (Type, Print)

11-05154 Linda Hartnett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 1 24580

		I- For State Registrar			Certi	ficate of	Death			Re	g. No.				
Physicia	an/	Decedent's Name (First, Midd	le,Last)						2	. Date of Deat Month	h Day	Year		3. Time of D	
્રાંcal Exami		Linda Hartnet	tt							July 10, 20	011			1821 h	îS
J.		4a. Facility Name (if not institution	on, give stree	t and number))	41	o. City, Town, or I	Location of	Death			County of	f Death		
		1 Circle Drive					Elkton					ecil			
Funeral		5. Social Security Number	6. Sex	7. Ag	je (In yrs. last	t birthday)	If Under 1 Year Months Days		24Hrs. Min.	8. Date of 8in	th (MM/D	D/YYYY)	9. Birth Foreign	place (State	or
Director		222-60-3355	1 M 2	2 X F	32	Yrs.	World Days	Hours	IVIIII.	03/08	/197	79	Cour	ter ()	DΕ
	ŀ	Usual Residence of Decedent													
any		10a. State 10b. County			10c. City, To	own or Locatio	n						- 1	10d. Inside	,
nd show	닐	MD Ceci:	1		E1k	ton								1 X Yes	2No
ne Maryland or 28a-f show fied at once.	둜	10e. Street and Number					10f. Zip Code			10	0g. Citize	en of Wha	at Count	y?	
he M	Director	119 E. Stockto	on Str	eet			2192	1			USA				
72 hours after death with the Maryland n "matural", or items 23s or 28s-f sho		11. Marital Status	12. V	Vas Deceden			Decedent of His	panic Origi				4. Race		an Indian, B	lack,
leath item	Funeral	1 Never Married 2 N	larried A	Armed Forces' Yes 2	? No	If Ye	s, specify Cuban,	, Mexican,	Puerto R	ican, etc.)	į	White	, etc.		
		3 Widowed 4 X Di	vorced if Yas,	Give Yaar		1 🗌	Yes 2 ∑ No	specify:			s	Specify:	Whi	te	
ntura ami	d b	15. Decedent's Education (Spe			mpleted) 1		s Usual Occupati				16b. Kii	nd of Bus	siness/In	dustry	
72 ho	Completed	Elementary/Secondary (0-12)	С	ollege (1-4 or	5+)	during mo	st of working life.	DO NOT	120 10(110)	u)	ł				
O36 ithin refise	d E	10	ł			Waitre						star		t	
othe Med w	ပိ	17. Father's Name (First, Middle	, Last)	`			1	18.Mother's	s Name (F	First, Middle, N	Maiden S	urname)			
21215-0036 Muld be filed within 72 hours after Mundal Hygiewei. marked other than "natural", c event, the Medical Examiner.	B	William Hartne								Wallac					
D 21	유	19a. Informant's Name/Relations	ship (Type, P	rint)	1		Address (Street							Zip Code)	
MD d 2 sho lth and n 27 is		Krystal Hartne	ett -	<u>niece</u>			Stockt			kton,	MD 2	21921	City on T	own, State	
e f Hea		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Re	moval from Si		ace of Dispositematory or other	ion (Name of cen er place)	netery,		Date	200. LC	ocation -	City Of 1	Own, State	
Pages ent o		4 Donation 5 Other S				ton Cer	netery		07/2	9/2011	E1	ktor	ı, Mi)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Montal Hygiene. Important: If titem 27 is marked other timinjury or other traumatic event, the Media		21. Signatur uneral Service		12/	02	22. Na	me and Address	of Facility	R.T	Foard	Fur	iera1	Hor	ne, PA	±
E L C E		Trail (-	yu	the	1	2.	59 East	Main	Stre	et, El	ktor	ı, MI	219		
Physician		23a. Part I Enter the disease, of failure. List only one cause	r complication	ns that caused	d the death. D	o not enter the	e mode of dying,	such as ca	rdiac or r	espiratory arre	est, shoc	k, or hea	ırt	Approxima Between	ate Interval Onset and
\/Medical		Immediate Cause (Final disease			o(Meth	adone	and Oxyo	odone	e) Int	toxicat	ion			De	ath
Examiner		or condition resulting in death)	Due to	o (or as a cons	equence of):		und way								
		Sequentially list conditions,	b								_				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	9	o (or as a cons	sequence of):										
	аш	(Disease or injury that initiated events resulting in death) Last	C.	o (or as a cons	sequence of):										
ecuted and transit	Ě		d												
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760, ficate be ex g physician the burial	/Mec	IF FEMALE:		c. If yes, outco	me of pregna	ancy					23d.	Date of	delivery		
		23b. Was decedent pregnant in past 12 months?	10.5	Live birth		===	al death 3	Ectopic	pregnan	су	10.1	Vionth	Da	ay	Year
Box 687 death certific he attending	Physician	1 Yes 2 No 9 ✔ Ur	nknown 4	Unknown	it time of deat	th 5 Oth	er (Specify) _				T				
he de hed f	ž	Part II. Other significant cond	اءا		th but not res	sulting in the ur	derlying cause o	iven in Par	rt I.	23e. Did to	obacco u	se contri	bute to ti	ne cause of	death?
, P.O. res that the signed by be detach	ģ	Cocaine Use	COITE	ipating to doc	or but not not	Jaking III (110 a.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 Yes	s 2	No 3	Proba	ibly 4 🗸	Unknown
Juires m sig		COCATHE USE			-				_	24a. Was	an	24b. V	Vere auto	opsy finding	s available
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Rec The la icate h	Eo									1 Yes			✓ Yes	2 [No No
tal Rection: The certificate ector, page	Be C	25. Was case referred to medic					26.Place	of Death (Check or						
Vital Records, sysician: The law require this certificate has been sidirector, page 2 should b	To B	examiner? 1 ✓ Yes 2 No	Hospita	^{al:} 1 Inpati	ient 2 🗌 E	ER/Outpatient	3 DOA	Other4	Nursing	Home 5	Residen	nce 6 🕎	Other.	Scene	
ing Ph After uneral	on: T	27. Manner of Death	2	8a. Date of Ing (Month, Day,		28b. Time of In		ry at Work?		28d. Describe subject				ethad	one
on: /	읉		nding f estigation	d 7–10	-11 f	d 6:07	pm 1	Yes 2 X		and oxy					
Division tal or Attendu rs after death. al Director: /	<u>2</u>		uld not be	28e. Place of I			t, factory, office b	uilding, etc	c. 2	28f. Location (or Town, S	Street an	Circ	er or Rur	al Route Nu	mber, City
Divi	Certificati		ermined	(Specify)	K	Residen	ce]	Elkton,					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after deach. When Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying	Physician: T	o the best of r	ny knowledge	e, death occurr	ed at the time, da	ate and pla	ce, and c	lue to the caus	se(s) and	manner	as state	d.	
To the Hos within 24 h To the Fun	edical	one) 2 Medical Ex		ne basis of ex manner stated		d/or investigati	on, in my opinion		curred at	tne time, date					
F 3 F 3	≗	29b. Signature and title of certif					29c. Licens							th, Day,Yea	r)
		11/0		7	as		O.C.	M.E.			July	11, 20	11		
p		30. Name and address of person	n who compl	eted cause of	death (Item 2	23a)					-				
,		Russell Alexander M		stant Medi	cal Exami	iner 900 \	N. Baltimore	Street,	Baltimo	ore, MD 21	223				
S	tate	31. Date filed (Month, Day, Year	r) /	32. Registr	ar's Signatur	الما									
Regis		A 110 0 0 0044	Denn	4 /4.	Mari										

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records, P.O.

Division of Vital

Ibrahim ADEBAYOF

			For State Registrar			tificate of E	Death		ene 2011	24582
Ī	Physicia Medic		Decedent's Name (First, Middle, L Adebayo	^{ast)} Fasasi	Ibra	ahim		2. Date of Death Month	Day 20/1	3. Time of Death
	Examir		4a. Facility Name (if not institution, gi	ve street and number) pital		4b. City, Town, or Lanh	Location of Death		4c. County of Deat	
	Funeral Director		5. Social Security Number 6. 400-94-4192		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8	3. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign untry) geria
	Maryland 28a-f show otified at	rector	Usual Residence of Decedent 10a. State 10b. County Prince	George	0c. City, Town or Loc Lanham	cation				10d. Inside City Limits 1 XYes 2 □ No
	with the is 23a or 3	Funeral Director	10e. Street and Number 7515 Newburg	Dr.			706		0g. Citizen of What Co	ountry?
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 ☐ Never Married 2 🏿 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔀 No		fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Bl a	e, etc.
21215-0036	within 72 ho giene. er than "nat , the Medica	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		(Give I	dent's Usual Occupa kind of work done o O NOT use retired) untant	ation during most of working		Account:	
Maryland	d be filed and the filed arked other tric event.	To Be	17. Father's Name (First, Middle, Las Alhajj Taosir	•			18. Mother's Name (i Alhaja			
, Man	and 2 should Health and Me em 27 is mari ther traumati		19a. Informant's Name/Relationship Sarah Awe Ibra				and Number or Rural F g Dr,Lank		City or Town, State, Zi	p Code) 20706
Baltimore,	~ 0 = -		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dispo cemetery, cren Family	natory or other plac	Da Y 7-22-			te,Nigeria
Ball	permit. Page Department Important: I any injury o		21. Signa ture of Funeral Service Lige	ensee Mate		Name and Address	ss of Facility 1 Mortua:	cy 4111	KennedyS	ngton,S.C. t,N.W.
, i	nysician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	-cstati	_	g, such as cardiac or r	respiratory arres	et,	Approximate Interval Between Onset and Death
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	ath certificate be executed attending physician and for use as the burial van it	sal Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a c	ti n	yolar	dial	Infer (chion.	
8760	tificate t ng phys as the I	Medical	IF FEMALE:	d						
. Box 68	g e	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	Sy		23d. Date of de Month	elivery Day Year
ds, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting in the u	ınderlying cause giv	ven in Part I.	1	acco use contribute to	o the cause of death? Probably 4 Unknown
Division of Vital Records,	The law ate has page 2	Completed by			_			24a. Was an autops perform 1 Yes 2	y prior to death?	atopsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpatier	LOth	ace of Death (Check of er:		nce 6 🗆 Other (Spec	cify)
Jo u	ding Ph th. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat	28a. Date of injury (Month, Day, Y	28b. Time of injury	work	v at 28		w injury occurred	
Divisio	al or Atter s after dea I Director d in by the	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 280 Place of Injury	- At home, farm, stre Specify)	eet, factory, office	28	3f. Location (Str. City or Town,	eet and Number or Ru , State)	ıral Route Number,
1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Exa	hysician: To the best of my miner: On the basis of exar urse Practioner: To the be	mination and/or invest	tigation, in my opinio	on, death occurred at th	ne time, date and	d place, and due to the	cause(s) and manner stated
	Virth Com		29b. Signature and title of certifier	Juni		29c. License	2810	29	9d. Date signed (Mont	
			30. Name and address of berson wh	o completed cause of dea	th (Item 23a) (Type, F			<u></u>		
	Sta	te	30. Name and address & berson when Azeez Abiod 31. Date filed (Month, Day, Year)	un, MD. 9	118 6000 Signature	d huck	ia, Lai	noin,	M1). 20	706
	Registr		JUL 182	UII Canona	p. 496					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

	•	For State Registrar		State of Ma		epartm Certifica			Mental F	lygien Reg. N	6 U		24583
Physicia Medic			e (First, Middle, Las o Jones	t)					2. Date of	Death 5 , 201 ^D	P ay	Year	3. Time of Death 4:20 р м
Examin	er	600 Cr	not institution, give			М	ill e rsvill				Anne	Arun	
Funeral Director		5. Social Security N 216-96-8 Usual Residence of	3815	7. Age M 2 □ F	(In yrs. last birth	rs. Monti	hs Days	If Under 24 Hrs Hours Min.	8. Date of (Month, Augus	Birth Day Year St 23,	1980	9. Birthp Coun V	place (State or Foreign try) ID
a-f show ified at	Director	10a. State	10b. County Anne Ar	undel	10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes 2本No
ns 23a or 28 nust be not	Funeral Dir	10e. Street and Nur	1	under	IVIIIIOIC	10f.	Zip Code 21108			10g. 0	Citizen of V	Vhat Cour	ntry?
ral", or iten Examiner r	۵	11. Marital Status 1 ፟፟፟፟፟ Mever Marr 3 □ Widowed	ried 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If Yes, s	cedent of His pecify Cubar s 2 - No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N to Rican, etc.)	10-		k, White,	ean Indian, etc. Black
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe	15. Decedent's Edecify only highest gra			Decedent's U (Give kind of life. DO NOT	work done di use retired)	ation uring most of wor ver Worke	5	16b.	Kind of Bu		dustry
Vental Hygi arked othe tric event,	To Be	17. Father's Name (18. Mother's Na Maria G		fle, Maidei	n Surname	e)	
ealth and N m 27 is ma ier trauma			ame/Relationship (T) DeVonya Jo	rpe, Print) ones – sister	19b.	Mailing Addr 600 Cr	ess (Street a ucible C	nd Number or Ru Court, Mille	ural Route Num ersville, l	nber, City o	or Town, S 108	tate, Zip (Code)
tment of H tant: If itel jury or oth				Removal from State	20b. Place of cemeters Hollar	Disposition (I I, crematory of Id Ceme	Name of or other place etery		Date 21, 201	1 Hu	Location - ntingto	own, N	
Depar Impor any in		21. Signature of Fu	neral Service Licens	Lewel	1		and Addres 1 Dares	s of Facility S Beach Rd	Sewell Fur ., Prince				78
ysician/ Medical			rt failure. List only o (Final		Monay consequence	. 1	mode of dying		or respiratory	arrest,			Approximate Interval Between Onset and Death
vaminer Lausit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying iinjury	b. Due to (or as a	consequence of		emix						
	edical Ey	resulting in death)		Due to (or as a	consequence of	n):							
	ΣΙ	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Petal death	3	oic pregnancy (specify)	y		_	23d. Dai	te of delive	ery Day Year
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is certific director,	To Be	25. Was case referred examiner?		Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Out	patient 3 🗆	Othe	r: 4 \(\sum \) Nursing F		esidence	6 □ Othe	er (Specify)
eath. or: After thi he funeral	Certificate:	27. Manner of Deatl 1 X Natural 2 Accident	5 Pending Investigation	28a. Date of injury (Month, Day,	/ 28b. Ti		28c. Injury work?	at	28d. Describ				
urs after de ral Directe lled in by t		3 ∐ Suicide 4 □ Homlcide	6 ☐ Could not be determined	building, etc.	(Specify)				City or 1	Town, Stat	te)		Route Number,
ithin 24 ho the Fune mpleted fi	Medical	(Check 2	Medical Exami	a Practioner: To the h	amination and/or	investigation,	in my opinior	n, death occurred	at the time, dat	te and place	ce, and due	to the car	use(s) and manner stated. ated.
≥ ¥ 8		> Y	m	MO	Physicia	n '	P56	950		Ju	ate signed	9 , 2	20 20
) 2		Maeme	ka Agaj	ompleted cause of de	ath (Item 23a) (T	Paul (dive 8	number 950 ruite 16	Glen B	vrnie	M	y) z	21.61
State Registra		31. Date filed (Mont		32. Registra	s Signature	A. S.	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 2252 M 121 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BULNIE - WASA MEd CUTA Olen 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** ^{Year)}1943 Months Days Hours Min March 22, 1 🗆 M 2 👿 F Yrs Washington, DC **Director** 216-40-8736 68 Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Shanks W. Va. Hampshire 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral items 23a USA HC 78 Box 22 26761 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 'natural", or 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 x Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ၉ Lonnie Hodge Catherine Brightwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Peggy Morrone / Daughter 66 Munson Lane, Hedgesville, WV 25427 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 Donation 3 Other (Specify) 2011 July 15. Edgewater 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events abete that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mhknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be

Box 68760 P.O. Records, of Vital nin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral or To the Hospital or Attending Division

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Deputy

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 06052

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

determined

5 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24585 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Manuel Tuly Louis Kramer 14 2011 Medical 615 P 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13820 Arctic Avenue Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months (Month, Day, Year) Country) Director Yrs 169-20-9793 05/17/1929 PΑ Usual Residence of Deceden or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville permit. Page 1 and 2 should be filed within 72 hours after death with the M. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n-n-any injury or other traumatic proces. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13820 Arctic Avenue 20853 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 1950-1951 16a. Completed by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner <u>Electronic Sale</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Kramer Clara Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Kramer - wife 13820 Arctic Avenue Rockville MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Judean Mem Grdns 1 X Burial 2 Cremation 3 Removal from State 07/17/20**1** Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M01163 Edward Sagel Funeral Direction Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, CKVIIIe | MD pr. 11 a 2 2 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Hypertensive Arteriosclerotic Heart Medical Examiner resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Congestive Heart Failure Examine Due to (or as a consequence of): 9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

124 hours after death.

126 hours after death.

127 hours after death.

128 hours after death.

139 hours after death. attending physician and for use as the burial-frame <u>Chronic Pancreatitis</u> that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Dav 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 \square Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury accurred 1 🔀 Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, D08089 July 18, 2011

State Registrar Leibowitz MD 11120 New Hampshire Avenue #305 Sil Pr 20904ng

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael E.

31. Date filed (Month, Day, Year)

JUL 2 0 2011

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of rtificate o			giene leg. No 2011	24586
	Physici		1. Decedent's Name (First, Middle, Las Bernard W. Kemp	•				2. Date of Dea Month July 8,	Day Vans	3. Time of Death 3:00a M
The same of the sa	/Medid Examin		4a. Facility Name (If not institution, give Brighton Gardens		man Lane	4b. City, Town, Bethes	or Location of Deat	h	4c. County of Death	
	Funeral Director		370-10-0073	X M 2 ☐ F 7. Age	92 Yrs.	if Under 1 Yea Months Day		8. Date of Birth (Month, Day April 2	(Year) Cou	nplace (State or Foreign Intry) Lington, DC
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County DC N/A		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	al Director	10e. Street and Number 5614 3rd Place, N	.W.		10f. Zip Code 2001			10g. Citizen of What Cou United Stat	•
980	be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Exemitive must be in filled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) If Yes, Give Year or Dates:	10	Was Decedent of If Yes, specify Co 1 □Yes 2 🗓 N	f Hispanic Origin? (Suban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	/	
1215-0	vithin 72 ho ene. Ihan "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+) (Give	DO NOT use retii	e during most of wor red)	rking	16b. Kind of Business/l	ndustry
and 2	should be filed within and Mental Hygiene. s marked other than " umatic event, Ita M	Be	17. Father's Name (First, Middle, Last) Thomas Kemp	5+		Attorney	18. Mother's Nar	me (First, Middle, s G. Steph	Maiden Surname)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.	10	19a. Informant's Name/Relationship (7		1,000	•	et and Number or R	ural Route Numbe	r, City or Town, State, Z	ip Code)
imore	Pages 1 atment of He tant: If iten jury or oth		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crei Washingt	on Natio	onal 07/1	Date 5/2011	20c. Location - City or T Suitland, N	AD .
Ball	permit Depart Import any inj		21. Signature of Funeral Service Licens	eee Webern					neral Servi Wash., D.C.	
	Physician /Medical Examiner		23a. Palvi. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each if a. Senile	the death. Do not ent ne. dementia a consequence of):	ter the mode of d	ying, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death Years
8	ficate be executed physician and streets the burial transm	dical Examiner	Sequentially list conditions, if any, leading to immediate Enter Underfair Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):				0	
O. Box 6	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as I	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregna ☐ Other <i>(specify)</i>			23d. Date of deli Month	very Day Year
rds, P.	w requires that s been signed b should be deta	ed by Ph	Part II. Other significant conditions co Essential hyperte		ut not resulting in the u	nderlying cause (given in Part I.	23e. Did to 1 ☐ Y	ebacco use contribute to res 2 ፟፟ No 3 ☐ Pro	the cause of death? obably 4 ☐ Unknown
l Reco	The law re ate has bee page 2 sho	Completed by						24a. Was a autop perfor	sy prior to o med? death?	topsy findings available completion of cause of
/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?			1		ath (Check only or		Assisted
=	hysi this c		1 ☐ Yes 2X No		nt 2 ER/Outpatier	IL OLL DON			lence 6X1Other (Spec	
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Day	v, Year) Injury	M 1	□Yes 2□No		ow injury occurred Street and Number or Ru	ıral Route Number.
<u>≥</u>	ospital or / hours after meral Dire y filled in b		4 ☐ Homicide determined 29a. Certifier 1 ♣ Certifying Physics	/sician: To the best	of my knowledge, deat	h occurred at the	time, date and plac	City or Tow	n, State) cause(s) and manner as	s stated.
	fo the Hc vithin 24 I fo the Fu ompletely	Medical	(Check only 2 Medical Examone) 2 Medical Exam	iner: On the basis of and manner sta	f examination and/or in	vestigation, in m	y opinion, death occ nse number	urred at the time,	date and place, and due	to the cause(s)
			Rynthia m	ompleted sauce of d	eath (Item 23a) (Tune	Drint\	58032		July 13, 20	_
			Cynthia M. Willia	ms, D.O.	3720 Upton	Street	, N.W. Was	shington,	D.C. 20016	Ď

State Registrar 31. Date filed (Month, Day, Year) JUL 18 2011



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24587 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 1:10a M Shirley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11506 Lockhart Place Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Country)
NY **Funeral** (Month, Day, Yea 5 / 8 / 1 9 3 Hours 1 □ M 2 😾 Director 80 114-22-411 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐XYes 2 ☐ No Silver Spring Md. Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 USA 11506 Lockhart Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕱No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Counselor</u> <u>School System</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Abraham Kantor Lillian Feinblatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14042 Weeping Cherry Dr. Rockville, Md₂₀₈₅₀ Lawrence N. Kay-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 DRemoval from State cemetery, crematory or other place 7/13/2**011** Falls Church, Va National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOO910

Danzansky Goldberg
Rockville, Md. 2085

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 Rockville Pik Interval Retween Immediate Cause (Final Onset and Death Physician, Stage Renal Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the buria transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Li retail 300 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2**X** No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred **X**Natural 5 Pending injury within 24 hours after deatn.

To the Funeral Director: Aft ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19/92 12/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY 3941 FERHALA DRIVE WHEATON UND HECHE, MD 31. Date filed (Month, Day, Year, State JUL 18 2011

Registrar

11-05285

Ricardo A. Leiva-Aldana

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of Fillit in Bia	CK IIIGEIDIE IIIK.	Flianic VII	Cobles VIE
State of Maryland /	Department of He	ealth and Me	ental Hygiene

2011	24	58	8

			1- For State Registrar			(Certifica	ate of	Death				Reg. No	201	1 24000
	hysici	an/	1. Decedent's Name (F	irst, Middle,La	st)	-					2	. Date of De Month	ath Day	Year	3. Time of Death
Medical I	Exami		Ricardo Ar	tonio :	Leiva-A	1dana						July 15,	2011		1734 hrs
			2 Way Diamor	ot institution, givend Avenue	e street and nu	ımber)		4	b. City, Town, oi Gaithersbu		f Death		- 1	c. County of Dear Montgomery	th
	neral		5. Social Security Num	ber 6. S	ex	7. Age (In y	rs. last birt	nday)	If Under 1 Yea		r 24Hrs.	8. Date of E	irth(MM	I/DD/YYYY) 9. B	irthplace (State or ign E1 Salvado:
Dir	ector		None	1[2	M 2 F		53	Yrs.	Months Day	's Hours	Min.	Marcl	n 17	,1958 c	ountry)
		Ì	Usual Residence of De												
	w any			o. County			City, Town		on						10d, Inside City Limits 1 X Yes 2 No
land	f sho	ō	,	rederi	ck		rede	rick					10.00		
Мал	23a nr 28a-f show notified at once.	Director	10e. Street and Number						10f. Zip Code				-	tizen of What Cod Salvado:	•
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ath w	or items must be	Funeral	1 X Never Married	2 Married	Armed F	orces?			es, specify Cuba				10-	White, etc.	ricari iridiari, biack,
fter de	", or		3 Widowed	4 Divorce	1 Yes If Yes, Give Yea	2 X N	10	1 X	Yes 2 No	specify:	E1 8	Savado	ran	Specify: W	hite
ours a	afura	d by	15. Decedent's Educa	ation (Specify o	or Dates: nly highest grad	de complete			's Usual Occupa				16b.	Kind of Business	/Industry
5-0036 ed within 72 hours after death with the Maryland	cal E	Completed	Elementary/Second	ary (0-12)	College (1	1-4 or 5+)						•	Ι.,.	1.1	
withir	Medi medi	Ĕ	8	at Adiabata I and	_		Cor	mmero	cial Tru			First, Middle		rucking	
21215-0036 uld be filed within 7	t ed of	BeC	17. Father's Name (Fir Manuel Ant			artine	ez					efina			
D 212 should be	Ment mark		19a. Informant's Name					o. Mailing	Address (Stre	et and Num	ber or Ru	ral Route No	ımber, C	City or Town, Stat	te, Zip Code)
MD d 2 sho	th and 27 is umati		Manuel A.	Orella	na (Son)	114	409 I	Key Park	way,	A-3,	Fred	eric	k, MD 2	1702
j and	ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner		20a. Method of Dispos		Pemoval fr		0b. Place of cremate Metr	of Dispositions	tion (Name of ce er place)	metery,	July	Date 7 17,	20c.	Location - City o	or Town, State
Baltimore, permit. Pages I a	r oth		4 Donation 5	_		OIII State		opo⊥: mato:			201		A ₁	exandria	a, Virginia
a ti	Department o Important: injury or oth	- 1	21. Signature of Funds		* 00				ame and Addres	s of Facility	DeV	ol Fu		1 Home	
			MAN /	Un	- 10	0689								ersburg	MD 20877 Approximate Interval
	sician aicai		3a. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fine list only one cause on each line. Immediate Cause (Final disease a Multiple Blunt Force Injuries										lock, or neart	Between Onset and Death	
	miner		Immediate Cause (Fin or condition resulting i		Multiple Blu Due to (or as a										Deadl
			Sequentially list condit	ions b		, , , , , , , , , , , , , , , , , , , ,									
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7 60, ficate be executed	ician urial -	/Medical	UNPENDED	x	AMENDED	28e 7/21/11	per m :FMW.M	e gy Month	18 8-8- 1 #28foerME	.7/26/1	1:EMW	LMbCb			
Box 68760, death certificate bo			IF FEMALE: 23b. Was decedent pre		23c. If yes,	outcome of p	pregnancy			Ectopic			23	3d. Date of delive Month	ry Day Year
Box 68 death certif	attending or use as	Sal	past 12 months?			nant at time o	of death 5		er (Specify)		program	-9		World	buy rour
Bo)	the att	Physician	1 Yes 2 No		9 OTIKN	<u> </u>									
P.O.	ed by detach	by P	Part II. Other significa	ent conditions	contributing to	o death but r	not resulting	g in the ur	nderlying cause	given in Pa	rt 1.				o the cause of death?
ures 1	n sign Id be	B										24a. Wa			utopsy findings available
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Record	icate h	튅										1 ✓ Yes	21	No 1 ✓ Y	
# E E	certif ector,	8	25. Was case referred examiner?		Hospital: 4 🖂					of Death (C. D. Co.		1		
of Vital	işi fi	욘	1 ✓ Yes 2 27. Manner of Death	No	28a. Date	Inpatient 2		utpatient Time of I n		ry at Work		Home 5		ence 6 🗸 Othe	er: Scene
ion of Vital	th. r: After t e funeral	<u>ë</u>	1 Natural 5	Pending	Jul 15,	Day, Year)	1730			Yes 2	P			k by train	
.∞ ₹	er death rector: by the	<u>icat</u>	2 Accident	Investigat	28e Plac	e of Injury -	At home, fa	rm, stree	t, factory, office	ouilding, etc	c. 2	8f. Location	(Street	and Number or R	tural Route Number, City
ical of	hours after d neral Direct y filled in by	Certification	3 Suicide 6 4 Homicide	Could not determine		Other (specify)	_ '	Train T	cacks	2	Westrown, Way Diam	State) ond Av	enue, Gaithers	sburg, Md.
Div	hin 24 hours after d the Funeral Direct npletely filled in by		20a Cartifier	rtifying Physic	ian: To the be	st of my know	wledge, dea	ath occurr	ed at the time, d	ate and pla	ce, and d	ue to the ca	use(s) a	nd manner as sta	ated.
To the	within 24 h To the Fur completely	Medical	one) 2 Me		r: On the basis and manner s		on and/or i	nvestigati			curred at t	the time, dat		ace, and due to t	
	1	Ž	29b. Signature and title	e of certifier			10		29c. Licens					Date signed (M	onth, Day, Year)
			MAN	1/	2		/ 7/		O.C.	M.E.			Jul	y 16, 2011	
			30. Name and address		completed cau Assistant N			9003	V Baltimore	Street	Raltimo	re MD 2	1223		
	-	tate	Russell Alexar 31. Date filed (Month, I					-		olioci,	Januario	, 1912 2			
	د Regis			2020	11 12	egistrar's Sig	p. 1	900							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar 24589 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month D7 Physician/ Joan Lucille Lotz 16 Medical 4a. Facility Name (if not institution, give street and number **Examiner** County of Death 100MICO 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K Months Days 8^{Mo}1th0^{Day}1^Y9^r3 3 Country) 77 MD Director 218-28-5392 Usual Residence of Decedent ortant, If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 11003 Gray's Corner Road #108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Production Personnel Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Montgomery Anna Imhoff permit. Page 1 and 2 should be Department of Health and Men Important, If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21811 #108 Berlin, MD Adam Lotz-Husband 11003 Gray's Corner Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
First State Crem. 1 Burial 2 X Cremation 3 Removal from State 7-20-11 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home <u> 108 William</u> Street Berlin, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/)BMBA disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vrtal Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent prechant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2/1 No 3 Probably 4 Unknown as been signal to a should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s performed 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) After this Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) **Matural** 5 Pending 1 Yes 2 No 2 🔲 Accident Investigation after death Director; / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Gorfffying Nurse Prentionar To the best of my knowledge obtained at the time, date and place, and due to the causely) and inture as etated 29b. Signature and title of certifier DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 SAZDBUL BAT WAN

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

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Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name	e (First, Middle	e, Last)					erunca	ate or t	Jeain		2. Date of D		201	1		Death C
Physicia Medic		Jol	nn	М.	Lut	У							Juli		3.2	Year O	11:4	12 M
Examin		4a. Facility Name (if	not institution	, give stre	et and nun	nber)			4b. Ci	ty, Town, o	r Location of	Death	(1 4	c. County	of Death)	
° Funeral		Meritus No. Social Security No.		Cen 6. Sex	ter	7. Age	In vrs. la	st birthda		gerst der 1 Year	OWN If Under 2	4 Hrs.	8. Date of B	irth	Wast		ton nplace (State o	r Foreian
Director		206-05-06	557		v1 2 □ F	····g- (95	Yrs	Month	s Days	Hours	Min.	(Month, E	ay, Year,	915 F	lays	ville,	PA
and show	or	Usual Residence of 10a. State	10b. County					,	Location								10d. Inside Ci	ty Limits
Maryla 28a-f	irect	PA	Frank	:lin			Way	nesb	oro								1 🗆 Yes	2 🔀 No
vith the 23a or st be n	Funeral Director	10e. Street and Num 902 Wes1		Uni	t B					Zip Code 7268				10g. 0	Citizen of V	Vhat Co	untry?	
tems er mu	Fune	11. Marital Status	,		. Was Dece		er in U.S	5. 1	3. Was Dec	edent of H	lispanic Origi	n? (Spe	cify Yes or No)-			ican Indian,	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marri		- 1	Armed For 1 Yes If Yes, Given Year or Date 1	2 □ N /e	0				an, Mexican, Specify:	Puerto i	rican, etc.)		Blac Specify:	k, White	, etc. hite	
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Dep Imp any) de	(2)	LBO	ves				50 S.	Broa	d St.	Way	ve-Bow ynesbo	erso ro,	PA 1	1era 1726	1 Home,	Inc.
-		23a. Part 1. Enter the shock, or hear	rt failure. List o	complica only one c	tions that o	caused thach line.	he death	n. Do not	enter the m	ode of dyin	ig, such as ca	ardiac o	r respiratory a	arrest,			Approximat Interval Bet	ween
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	200.		Birth 2 nant at t	☐ Feta	death	3 🗌 Ectopi 5 🗌 Other		cy				23d. Dat Mor		*	Yea r
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Hosp 24 hou Funel leted fil	Medical	(Check 2	Certifying Medical B	xaminer:	On the bas	sis of exa	mination	and/or in	vestigation,	in my opinio	on, death occ	urred at	the time, date	and place	ce, and due	to the c	ause(s) and mai	nner stated.
To the within To the Compl		29b. Signature and t			actioner.	TO LITE DE	St OI IIIy	Kilowieug	2	9c. License	e number			29d. Z	ate signed	(Month.	Dav. Year)	
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State of Maryland / Department of Health and Mental Hygiene 2011 24591 Reg. No. 2. Date of Death 3 Time of Death Month Day July 17, 2011 0844 hrs 4b. City, Town, or Location of Death 4c. County of Death Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Hours Gwantemala 2/28/1987 10d. Inside City Limits 1 Yes 2 No with the Maryland Director 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country' 1414 University Blvd Apt.201 20782 Guatemala 238 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nohours after death 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 2 X No 1 Yes Guatemalan White If Yes, Give Year or Dates: 1 X Yes 2 No specify: 4 Divorced Specify. ρ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 lear of Health and Mental Hygiene.
ant: If item 27 is marked other than ", or other traumatic event, the Medical E MD 21215-0036 Landscape worker Landscape 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Santos Gregorio Agustin Mendez Emiliana Morales Perez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pedro De Jesus Lopez/uncle 5209 54th Avenue Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Aldea El Camaron, Municipal Cemetery 8/4/2011 Donation 5 Other Spe Jalapa, Guatemala 21. Signatur PHYTERPACES RIVALDI FUNERAL SERVICE, P.A 9241 Columbia blvd.Silver Spring,Md20910 23a, Part I. Enter ti e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line /Medical Between Onset and Death a. Drowning Immediate Cause (Final disease ≟xamineı or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated The law requires that the death certificate be executed Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a,27,28a-f,per me,g918 8-11-11 sm Item as noted,per me,g918 8-17-11 sm UNPENDED attending physician or use as the burial X Box 68760 IF FEMALE: 23c. If yes, outcome of pregnance 23d. Date of delivery . Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? <u>م</u> ٦ 1 Yes 2 No 3 Probably 4 ✔ Unknown Records. Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has certificate has ector, page 2 sl performed? death? ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) director Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this DOA 1 🗸 Yes 2 No After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A 1 Natural 5 Pending 1 Yes 2 X No Subject drowned the f 2 Accident fd 7-17-11 fd 8:44 am Investigation completely filled in by 28e Place of Injury - At home, farm, street, factory, office building, etc. subject found floating in a (Specify) body of water 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7801 West Park Dr. 3 Suicide Could not be (Specify) body 4 Homicide determined Hyattsville, Md. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 18, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 2°8 32. Registrar's Sign State 2011

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Mercy
4a. Facility Name (if not institution, give street and number) /7/201 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospita Montgomery

9. Birthplace (State or Foreign Country) Rockville 8. Date of Birth (Month, Day, Year) 12/23/1943 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Funeral 1 □ M 2 F Hours Director 67 Ghana None Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🙀 Yes 2 🗆 No Montgomery Md. Germantown 10g. Citizen of What Country? Funeral 20874 Ghana 12857 Kitchen House Way Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 5 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Unknown Ferguson Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12857 Kitchen House Way Germantown, Md. 20874 Edward Mireku-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Kaneshi 9/16/2011 Accra, Ghana Cemetery permit. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Immediate Cause (First) | Approximate Signature of Funeral Service Licensee 22. Name and Address of Facility Interval Between Onset and Death Immediate Cause (Final cerebro vas cular accident Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examine piraton Sague tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transm the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate it 1 Yes 2 No 1 ☐ Yes 2 🛱 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 × No Other: I 🄀 Inpatient 2 □ ER/Outpatient 3 □ DCA 4 Nursing Home 5 Residence 6 Other (Specify) Completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07/08 200 68080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, Medical Jalli, MD 990 Sirresha 31. Date filed (Month, Day, Year) State 18 2011 Registrar

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		Registrar 1. Decedent's Name (First, Middle	e, Last)	Uel	incate of Deat		Reg	J. No. UII	1
Physic			•	MEDADA			Month	Day Year .0 2011	3. Time of Death 2:14 A M
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			MEMORIAT, HOS	TAMAT	FREDERICK	_		FREDER	
Funera	al	FREDERICK 5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Un	nder 24 Hrs. 8	. Date of Birth	9. Bi	rthplace (State or Foreign
Directo		none	1 □ M 2 🖾 F	55 Yrs.	Months Days Hou	irs Min. 3	3 / 2 to 7 th 9	936 E	ameroon
d ow	٦.	Usual Residence of Decedent	-						
yland -f sh ed a	댱	MD 10a. State 10b. County	lerick	10c. City, Town or Loc Frede					10d. Inside City Limits
e Ma r 28a notifi	Director	10e. Street and Number		11000					1 🏝 Yes 2 □ No
ith th	rall	9719 Fleetwo	veW bor		10f. Zip Code 21701		100	g. Citizen of What C	
Ind 21215-0036 filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Marical Examiner must be notified at	Funeral	11 Marial Carter		Tues in LLC 42 V	1	Ovisin2 (Cassife	Van ou No	Came	
or ite			12. Was Decedent 8 Armed Forces? ried 1 \(\text{Yes} \) 2 \(\text{T} \)	1	Vas Decedent of Hispanic Yes, specify Cuban, Mex			14. Race - Am Black, Whi	
S afte	l b	3 ☐ Widowed 4 ☐ Divorced	If Van Ciua	1	☐ Yes 2 🖾 No Spe	cify:		Specify: B	lack
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Page 1 ment of ant: If it ury or o		1 Burial 2 Cremation			natory or other place)	Date		c. Location - City o	
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o my nijury or other traumatic event, the M. iteal Exam		4 Donation Other (S			Cemetery				Cameroon
Baltimore permit. Page 1 a Department of H Important: If itel any Injury or ott		21. Signature of din all Styvice (truft	92	Pare Propess Rice 241 Columb	NALDI ia Blv	FUNERA d.Silv	L SERVIC er Spri	CE,P.A. ng,Md20910
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do not ente	r the mode of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	MET	ASTATIO	BREAD	ST CAN	YCER		Onset and Death
Medica Examine		resulting in death)		a consequence of):					
ZAGITINIO		Sequentially list conditions,	b. —						
B 6	Examiner	cause. Enter Underlying Cause (Disease or linjury	Dua to (or ease	e consequence offr					
and	Exal	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):					
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/ 6U icate b physi s the b	1 (1)		d						
certific nding use as	N S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	liven
box death death are atter	Physician/Me	in the past 12 months?	4 Pregnant at	2 ☐ Fetal death 3 ☐ time of death 5 ☐	Ectopic pregnancy Other (specify)			Month	Day Year
at the d d by the etachex	hys	1 Yes 2 No 9 Unknown	g ∐ Unknown						
gned gred	by	Part II. Other significant condition	ns contributing to death be	ut not resulting in the ur	nderlying cause given in P	art I.	23e. Did tobac	co use contribute to	the cause of death?
dS, quires en sig	led						1 🗆 Yes	2 No 3 F	Probably 4 🕱 Unknown
VICAL MECOTOS, ysician: The law requires s certificate has been sig	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The late has page	S I						performe	d? death?	s 2 🗆 No
ctor,	Be (25. Was case referred to medical examiner?	l .		26. Place of [Death (Check on			
hysic his ca al dire	은	1 Yes 2 No		ent 2 KER/Outpatient	3 □ DOA Other: 4 □	Nursing Home	5 Residenc	e 6 Other (Spec	cify)
ing P	Certificate:	27, Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date of injur (Month, Day		28c. Injury at work?		. Describe how i	injury occurred	
VISION OI or Attending Pl frer death. irector: After th n by the funera	tific	2 Accident Investig 3 Suicide 6 Could	not be		M 1 □ Yes 2				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transpace.	Cel	4 Homicide determ	building, etc	ry - At home, farm, stre . (Specify)	et, ractory, office	28f.	Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
Spita nours neral	ical	29a. Certifier 1 X Certifying	Physician: To the best of r	my knowledge, death or	ocured at the time, date a	ind place, and di	ue to the cause(s	s) and manner as st	ated.
n 24 h n 24 h ie Fui	Medical	(Check 2 Medical E	xaminer: On the basis of ex	amination and/or investig	gation, in my opinion, deatl	h occurred at the	time, date and p	lace, and due to the	cause(s) and manner stated.
withi	_	29b. Signature and title of certifier			29c. License numbe	er	29d.	. Date signed (Mont	
_3		1			00062	223		07/11/2	011
		30. Name and address of person v	who completed cause of de	eath (Item 23a) (Type, Pr	29c. License number 0 006 20 int)		102/2	N.	
			LARUY 19	6 TJ Duev	E TREOG!	uce, M	WUT	04,	
Sta Regist	ate rar	31. Date filed (<i>Month</i> , <i>Day</i> , <i>Year</i>) JUL 18 2	2. Registra	r's Signature	20.	/			
		JUL 10 Z	- Level	F . (T					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Month 18^{Day} 20ÎÎ 4:39 P M James Edward Murphy, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Clinton <u>5813 Terence Dr.</u> 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe **Funeral** Days Hours Min 1 **X** M 2 □ F Months November 1931 Pennsylvania **Director** 176-22-7117 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Clinton Maryland Prince Georges 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? with 1 Funeral items 23a 20735 U.S.A 5813 Terence Dr. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ō 9 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Metropolitan Police Dept. Sgt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Edward Murphy, Sr. Romaine Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Ann Murphy (Daughter) 5813 Terence Drive, Clinton, MD 20735 Baltimore, Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) July 25, 2011 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Resurrection 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licen ^{çee} MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner CAADONASCIRAR OLGASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last nding physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 \square Pending work?
1 Yes 2 No s after death. I Director: Aft Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier

State Registrar

RBST

LINE CENTER WALDERF, MA

son who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15 Day **Physician** 2011 6:41 Рм Angelina Mockabee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9232 Atlantic Avenue North Beach Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 M 2 X F 579-52-2412 80 **Director** 10/17/1930 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expensiver must be notified at Director 1 ☐ Yes 2 No MD Calvert North Beach 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 9232 Atlantic Avenue 20714 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural', or i Maryland 21215-0036 1 ☐Yes 2 No Specify ò Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Louis DiGiorgi Innocense Cataldi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Dotson / Daughter 9232 Atlantic Avenue, North Beach, MD 20714 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 07/20/2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral or rvice Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. any Lisa M. Mounts 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MEMS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) be executed and Due to (or as a consequence of): burial-Box 68760. physician CERTIFICATION Physician/Medical that the death certificate the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Month Day 5 Other (specify) ed by the Ö 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The certificate performed 2 **X**No Vital 1 □Yes 2 No 1 □ Yes Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA this ot funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 12 After or Attending Division 1 Natural 2 ☐ Accident 5 Pending thead-susperted 7-15-2011 within 24 hours after death. To the Funeral Director: ₽ investigation Unknow 1 □Yes the 28f. Logstion (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ determined 4 Homicide filled in Hospital 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifia

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Avenue, North Beach, MD 20714

completed cause of leth (Item 23a) (Type, Print)

recent

32. Registrants Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

avid Eugene M		n State	ate of Maryla	and / De	epartmo	ent of	Health	and	Menta	Ну		eg. No. 2 (9	24596
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Middle David Eugene Morto								1	2. Date of Deat Month July 22, 20	th Day	/ear	3. Time of Death 1508 hrs
ijedicai Examii		4a. Facility Name (if not institution Anne Arundel Medical	n, give street and nu	imber)		4	b. City, Tow		ocation of (Death	ouly EE, E	4c. Coun	ty of Dea	
Funeral Director		5. Social Security Number 215-64-4316	6. Sex	7. Age (In)	rs. last birt	hday) Yrs.	If Under	1 Year Days	If Under 2 Hours	24Hrs. Min.	1	th(MM/DD/YY	Fore	irthplace (State or ign Washington country) D.C.
nd show aoy		Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	10c.	City, Town	or Locati								10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show netified at ooce.	Dire	10e. Street and Number 2564 North Ha					10f. Zip Co	214					ISA	
ter death wi	by Funeral	11. Marital Status 1 XXNever Married 2 Ma 3 Widowed 4 Div	arried Armed For 1 Yes or Dates:	orces?	No	1	es, specify (Cuban, I	Mexican, P	uerto F		Specil	hite, etc. y:	w hite
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12th				during mo	t's Usuat Oc ost of workin Worke:	ng İife. C r	OO NOT us	e retire	ed)		stru	ction
P 2 5 5	Be	17. Father's Name (First, Middle, Robert F. 19a. Informant's Name/Relations	Morton		19	b. Mailing	Address		Kay	у Со	First, Middle,			te, Zip Code)
re, MD s 1 and 2 sho f Health and if item 27 is er traumati	-	Kay C. Morton/ 20a. Method of Disposition 1 X Burial 2 Cremation	Mother	rom State	20b. Place cremat	of Dispos tory or oth	ition (Name ner place)	of ceme			Date	20c. Location	on - City	y1and 21401 or Town, State
Baltimore, permit. Pages la Department of He Important: If ite iojury or other to		4 Donation 5 Other St. 21. Signature 1 Donation 2 Other St. 21. Signature 1 Donation 2 Other St. 21. Signature 2 Other St. 21. Signature 2 Other St. 21. Signature 2 Other St. 22. Signature 2 Other St.	pecify:		Sacred	22. N		ddress o		eoi		Kalas	Fune	ryland ral Home MD 21037
Physician Medical Axaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. Alcohol	and	Fenta					diac or	respiratory arr	est, shock, or	heart	Approximate Interval Between Onset and Death
	ē	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a											
executed an and al - transit	Examine	cauce. Enter Underlying Cauce (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	·	,					_				
K 68760, h certificate be executed tending physician and use as the burial - transit	/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the		outcome of	pregnancy				.8 8-1	_		23d. Date		ery Day Year
Box 68760 e death certificate b the attending physi	Physician/Med	past 12 months?	4 Pregi	nant at time lown	of death	5 Ot	tal death her (Specif					(4)		to the cause of death?
v requires that the speed signed by should be detach	2	Part II. Other significant condit	ions contributing t	o death but	not resultir	ng in the u	inderlying c	ause giv	ven in Part	i. —		s 2 No	3 P	obably 4 Unknown autopsy findings available
Vital Record ysician: The law re his certificate has be director, page 2 sho	Completed	25. Was case referred to medical					26	.Place o	of Death (C	heck o	1 Yes	rmed?	prior t death	
	on: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen	Hospital: 1 28a. Date (Mont	Inpatient e of Injury h, Day,Year)	28b.	Time of I	`	c. Injury	other ₄ at Work?		Home 5 28d. Describe			ner:
Division of ' To the Hospital or Attending Ph within 24 hours after death. To the Fuoeral Director: After I completely filled in by the funeral	Certification:	2 Accident Inve	stigation I Q /	-22-11 ce of Injury -				-			28f Location (Street and Nu State) 2564	Nor	Rural Route Number, City th Haven Cove
Divis To the Hospital or A within 24 hours after To the Fuorral Dire completely filled in b	Medical (one) 2 Medical Exa	hysician: To the beaminer:On the basis and manner	of examina	owledge, de tion and/or	eath occur investiga	tion, in my c	pinion,	e and plac death occu	e, and urred a	due to the cau t the time, date	and place, ar	nd due to	tated. the cause(s) Month, Day, Year)
	2	29b. Signature and title of certification of certification of the second	ell, MI)	use of death	(Item 23a)			O.C.N				July 23,	-	
1 ⁰ 12 s	tate	Pamela E. Southall, National Date filed (Month, Cay, San	MD Assistant	Medical egistrar's S	Examine	er 900	W. Balt	imore	Street,	Baltir	nore, MD 2	21223		
Regis		JUL 2	2011	enma	p.	1400	Comme							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20^{Year}1 Alice M. Moreland 1214 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Rirth 9. Birthplace (State or Foreign Funeral Oct 25 1 □ M 2 🔽 F Months Hours Maryland 1925 **Director** 220-16-8967 85 Usual Residence of Decedent 28a-f show 10a. State 10h. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Mary1and Anne Arundel Lothian 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 870 Marlboro Rd. 20711 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Yes 2 No vithin 72 hours after Maryland 21215-0036 1 ☐ Yes 2 If Yes, Give 1 Yes 2X No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8th 0 Nurse Assistant Crownsville Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Henry Johnson Mary Anne Hardesty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7905 Thrush Meadow Place Severn, Md. <u> Sandra Moreland(Daughter)</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Zion UM Churchi 7-13-11 Lothian, Md. Signature of Funeral Service Licensee Amame are essent Facilitisons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No. Hospital Other: 1 Yes patient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28a. 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Natural Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) MI son who completed cause of death (Item 23a) (Type 30. Name and addres 31. Date filed (Month State strar's Signature

DHMH 17 Rev 7/2009

Registrar

11-05182 Noel McBride 28a-f show

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24598 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 11, 2011 Noel Francis McBride 2006 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Crofton Anne Arundel 1448 Harwick Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Wash. DC 220-92-7056 Months Hours Director 42 Jan. 9, 1969 1000M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Anne Arundel Annapolis 1 Yes 2 No n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner must be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 546 Fawns Walk 21409 U.S.A. $\overline{\Box}$ 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1XX Never Married 2 Married Yes 2 X No White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Golfer Golfing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joseph F. McBride Judith Lee Kennedy Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith McBride/mother 546 Fawns Walk Annapolis, Maryland 21409 item 20b. Place of Disposition (Name of cemetery, 20a Method of Disnosition 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 7/15/2011 Baltimore, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Fundral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Inhalation of Helium Gas Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Cal AMENDED UNPENDED ician/Medi Division of Vital Records, P.O. Box 68760, 1tal or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 ✔ No 3 Probably 4 Unknown eted certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of perform death? Yes 2 ✔ No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes 2 No After 28a. Date of Injury FOUND: Day,Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Subject purposefully inhaled helium gas 1 Natural FOUND 1 Yes 2 ✔ No Pending within 24 hours after death. To the Funeral Director: completely filled in by the Jul 11, 2011 2000 hrs Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1448 Harwick Court, Crofton, Md. determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 12, 2011 Decesse 4 30. Name and eddress of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

31. Date filed (Month, Day, Ya5 2011

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend#14 per FH State Registrar 7/21/2011 CMH AACO HEALTH DEPT 24599 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:00 M eMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** . County of Death Anne Arundel Laurel 314 Park Hall South Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 👿 M 2 🗆 F Months Days Hours Min June 15, 1944 Tennessee **Director** 411-72-0881 67 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Laurel Maryland Anne Arundel 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20724 USA 314 Park Hall South 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 V No Specify "natural" 3 Widowed 4 Divorced Specify Laurel White Completed 63 - 67the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Letter Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lucy Gordy James B. Meroney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Meroney-WIFE 314 Park Hall South, Laurel, Maryland 20724 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Laurel, Maryland Baltimore Washington Crem. July 12, 2011 4 Donation 5 Other (Specify) 21, Signature of Funer e Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd, Laurel, Maryland 20707 mol23 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) /sician and e burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical e attending phy... Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 ☐ Yes ≥ ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 No 1 Yes of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the leted filled in by the funera 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident 3 Suicide 5 Pending Division 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier npleted within 2 To the 29b. Signature and title of certif 2011 Name and address of person who completed ise of de ath (Item 23a) (Type, Print) Blud, Eldesbura 90 State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY McFerren 2011 William . 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Washington Boonshoro Reeder's Nursing Home If Under 1 Year | If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) 12 23 1934 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 76 180-26-6124 Waynesboro, PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

10f, Zip Code

17268

1 Yes 2X No Specify:

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 X Yes 2 No

Year

10g. Citizen of What Country?

14. Race - American Indian,

white

Black, White, etc.

US

Waynesboro

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 XNo

Director show notified at 28a-f ō event, the Medical Examiner must be with items 23a ò and Mental Hygiene.
is marked other than "natural", permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Physician/

Medical

Examiner

Funeral

For State Registrar

10a. State

PA

10e, Street and Number

11 Marital Status

Franklin

211B Elder Ave.

1 Never Married 2 Married

3 Widowed 4 Divorced

Director

Funeral

<u>Ş</u>

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760

Division of Vital Records,

If Yes, Give Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance worker local government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mildred Walker James A. McFerren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8828 Reichard Road Fairplay, MD Sheila Grimm 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Waynesboro, PA 7/29/2011 Green Hill Cemetery 4 Donation 5 Other (Specify) Grove-Bowersox Funeral Home, Inc 21. Signature of Fundal Service Licensee 22. Name and Address of Facility 50 S. Broad St. Waynesboro, PA DOLLER 23a. Part 1. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 12 10 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID MAHMOOD, 580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 301-733-4496

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Registrar

31. Date filed (Month, Day, Year) AUG 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item per fh g918 8-8-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death ^D2011 Physician/ July Sophie M. Narcavage 14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Care & Rehab Center Crofton Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Date or Day, You are 18 1 🗆 M 2 🕱 F Months Days Hours Min. Year 1919 Pennsylvania Director 175-01-6774 92 Jan. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2131 Davidsonville Rd. 21114 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give 3 XWidowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Dress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Novak Mary Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Narcavage / Son 1711 Tedbury St., Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Michaels 7/19/2011 Simpson, PA Cem. 21. Signature of Fuheral Service Licensee 22. Name and Address of Facility Beall Funeral Home any. 6512 NW Crain Hwy., Bowie, MD av 1. Enter the disease, or co mock, or heart failure. List only nplications that ca sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner roversalan Di Sa Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical \circ Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluo 1 🗀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pace 2 s has autopsy performe this certificate 2 No 1 🗌 Yes Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 XNursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner. On the basis of examination allow investigation, if in, operating date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and thie of certifier 29d. Date signed (Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane, Bowie, MD 20715

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL

182011

2. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	arylan		artment of I tificate of L		nd Mental Hy	giene Reg. Na	2011	24602
Ī	Physicia	n/	1. Decedent's Name							2. Date of Dea	ath		3. Time of Death
	Medic Examin	al	4a. Facility Name (if		ATHER, SR	•		4b. City, Town, o	r Location of D	07/16/ Death		L. County of Deat	<u> 5:45 A ^M</u>
San and	<i>}</i>				omery Hos			Rockvil				ontgame	
	Funeral Director		5. Social Security Nu 578-24-30	092	X M 2 □ F 7. Age 8'		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birt Vin. (Month, Da 05/24/		9. Bir 4 MD	thplace (State or Foreign nuntry)
	and show at	or	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
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	ith the 23a or st be n	ralD	10e. Street and Num	^{nber} shen Road				10f. Zip Code 20879			10g. Ci	tizen of What Co	ountry?
	leath w	Funeral Director	11. Marital Status	Shell Road	12. Was Decedent E	ver in U.S	6. 13. V	Vas Decedent of H	ispanic Origin	? (Specify Yes or No-	0021	14. Race - Ame	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Marri		Armed Forces?. 1 Yes 2 If Yes, Give Year or Dates.	No		Yes, specify Cuba		uerto Rican, etc.)		Specify: B.	e, etc. Lac k
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Ma	d 2 sho alth an 1 27 is er trau			me/Relationship <i>(Ty</i> , Lizabeth	Prather <i>/x</i> /	D fe	1			r Rural Route Numbel Gaithersb u			
Baltimore,	je 1 an t of He If item or othe		20a. Method of Disp	osition	Removal from State	20b. R		sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State
<u>Hi</u>	artmen ortant: injury		4 Donation 21. Signatur 1 Fun	5 Other (Specify		Byd		cove Ch C		7/22/11		ithersb	
Ba	permi Depar Impo any ir once,	Į,	De	uge t	Summe	de	* 2	246 N. Wa	shinata	Snowden Fon St, Roo	kvi		
			23a. Part 1. Enter the shock, or hear	ne disease, or comp t failure. List only or	lications that caused cause on each line	the de h	n. Do not ente	r the mode of dyin	g, such as car	diac or respiratory arr	rest,		Approximate Interval Between
	Medical		Immediate Cause (find disease or condition resulting in death)		a. Lung Ca								Onset and Death
	Examiner	L	Sequentially list cor	nditions	h	Consequ	crice oi).						
_	pa 🗘	Examiner	if any, leading to im cause. Enter Under	mediate lying	Due to (or as a	a consequ	ence of):						
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687	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome			1 -				23d. Date of de	livery
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial term.	Physician/M	in the past 12 n 1 Yes 2 9 Unknown	nonths?	1			Ectopic pregnand Other (specify)	У			Month	Day Year
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900	law re has be je 2 sh	Completed							- %	24a. Was a autop	sy	prior to	topsy findings available completion of cause of
a B	an: The tificate tor, pag	Be Co	25. Was case referre	ed to medical				26. PI	ace of Death (0	perfo 1 Yes Check only one)	2 🔀 N	o 1 🗆 Yes	s 2 No
Ę.	hysici this cer al direc	욘	examiner?	34110			ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗆 Nursir		lence 6	XOther (Spec	ify) Hospice
o u	nding Fith. th. After i	cate	 Manner of Death Matural Accident 	5 Pending Investigation	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injun work M 1 🗌		28d. Describe h	ow injur	y occurred	
Division of Vital Records, P.O.	or Atter fter des irector n by the	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju	ry - At hor (Specify)	me, farm, stre	et, factory, office		28f. Location (S City or Tow			ral Route Number,
ā	spital or spital or neral D		29a. Certifier 1	☐ Certifying Phys	ician: To the best of	my knowle	edge, death c	ccured at the time	, date and plac	ce, and due to the cau	use(s) ar	nd manner as sta	ated.
	the Ho hin 24 I the Fu npleted	Medical	only one) 3	Certifying Nurs	ner: On the basis of exe e Practioner: To the	kamination best of my	and/or invest knowledge, o	eath occurred at the	e time, date and	red at the time, date a d place, and due to the	nd place e cause(s	, and due to the o s) and manner as	cause(s) and manner stated. stated.
	2 ¥ € Ø		29b. Signature and t	the of certifier	micke		DAIP	29c. License	1432		29d. Da	te signed (Month	ı, Day, Year)
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	Stat	e	Deboran 31. Date filed (Month	Miller,		_			au, RO	ckville, M	ו2 עני	0000	
	Registra		JU	L 20 2011	Centur	, A.	fa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Ar 2 Legible. 24603 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 9, Physician/ 2011 Thinh Phan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 30 Shady Grove Adventist Hospital Rockville 77 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number **Funeral X**M 2 □ F Months Days Min Hours 213-82-5337 87 Director May 31, 7011 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location Director MD Montgomery Montgomery Village 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral June 19310 Club House Rd # 317 B 20886 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Diplomat Be

	14. Race - American Indian, Black, White, etc.					
Specify: Asian						
16b.	Kind of Business Industry	_				

Vietnam

4c. County of Death

Montgomery

U.S.A.

Government

3. Time of Death

р

10:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 K No

M

17. Father's Name (First, Middle, Last)

Hy Van Phan

Can Thi Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print) Tu-Trang Phan - Daughter 20a. Method of Disposition

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

4007 Connecticut Ave N.W. #308 Washington D.C. 20008 20c. Location - City or Town, State

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Termation 3 Removal from State National Crematory

July 16,2011 Falls Church, VA 22. Name and Address of Facility National Funeral Home

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

2

Baltimore,

Physician/

Medical

Examine

Medical

Physician/

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Completed

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Certificate:

Medical

Examiner

Kansir

physician a s the burial-

attending p

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s been signed by should be deta

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page certificate

funeral director,

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

assivation neumonia or as a consequence of) monary

7482 Lee Highway Falls Church,

Due to (or as a consequence of):

Due to (or as a consequence of)

Approximate Interval Retween Onset and Death

if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Sequentially liet conditions

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Pregnant at time of death

oulmonory

clostridium

coronary

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

23d Date of delivery

9 Unknown

9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. obstructive cardio myopath

24a. Was an

1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of

25. Was case referred to medical 1 Yes

Hospital 1 1 Inpatient 2 ER/Outpatient 3 DOA

autopsy performed? Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

2 🔊 No 27. Manner of Death

Matural 1

28a. Date of injury (Month, Day, Year) 5 Pending Investigation

28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No iniury

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Other:

28f. Location (Street and Number or Rural Route Number

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year) July 10, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

604 South Frederick Ave. #413, Gaithersburg, Maryland 20877 Abul takkag

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24604 State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 14 2011 Year Physician/ Mary Hoffman Pearce 9:43 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montaomeru Silver Spring 3563 S. Leisure World Blvd.. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Min. Hours (Month, Day, Year) 12/21/1914 Country Maryland 96 Director 216-01-8251 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits at Director Medical Examiner must be notified Silver Spring 28a-f 1 🗌 Yes 2 🎛 No Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23a** Funeral U.S.A. 20906 3563 S. Leisure World Blvd., #1B Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 0 1 Never Married 2 Married þ Yes 2 X No **3altimore, Maryland 21215-0036** If Yes, Give 1 Yes 2 X No Specify. 'natural", Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) St. Matthews Pre-School Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher - P.G. County Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Agnes Hamilton Boyd James Wilbur Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29505-H Ridge Manor Dr., Damascus, Maryland 20872 Mary Pearce Outman - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 07/19/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 M01524 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Dehydration disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Chronic Alzheimer's Disease Sequentially list conditions, if any leading to improve if any leading to immediate cause. Enter Underlying Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Year Day Pregnant at time of death the 1 ☐ Yes ∠ ∠ 9 ☐ Unknown Unknown nas been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hupothuroidism 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Recorto the Hospital or Attending Physician: The law requestion of the Funeral Director: After this recording the funeral Director: After this recording the funeral Director. 24b. Were autopsy findings available prior to completion of cause of death? Arthritis 24a. Was an autopsy performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital: Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c, License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas R. Shumaker,

18 2011

31. Date filed (Month, Day,

D27301

M.D., 615 W. Montgomery Avenue, Rockville, MD 20850

July 14. 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24605 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day}2011^{Year} July Jack Willis Phleeger 5:26 A^{M} 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 402 W. Hillcrest Rd. Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 30, 1928 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min. Maryland 216-22-8625 82 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County Hagerstown 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 402 W. Hillcrest Rd. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Bowling Alley 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Willis Phleeger Pauline Osborne Phleeger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Phleeger-wife 402 W. Hillcrest Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rest Haven Cemetery 7-22-2011 1 X Burial 2 Cremation 3 Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify)

Physician/ Medical Examiner

Physician/

Medical

Director

Completed by Funeral

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nijury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service Licensee	22. Nan	22. Name and Address of Facility Douglas A. Fiery Funeral Home							
\angle	Deurla N. Fren	1331	Eastern BLvd.	North H	lagerstow	n, MD 2	1742			
	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Interva	Approximate Interval Between Onset and Death							
je.	resulting in death) Due to (or as a sequence Sequentially list conditions, b.									
Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence)									
ledical	d									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	opic pregnancy er (specify)				delivery Day Year				
ted by Pl	Part II. Other significant conditions contributing to death but not resulting	Yes 2□No 3	te to the cause of death?							
Comple										
Be	25. Was case referred to medical examiner? Hospital:	ck only one)								
10	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
ficate:		Time of injury M	28c. Injury at work? M 1 □ Yes 2 □ No							
I Certi	4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, fa	ctory, office		Location (Street and Number or Rural Route Number, City or Town, State)					
Medical Certificate:	29a. Certifier (Check only one) 1									
_	29b. Signature and title of certifier					Month, Day, Yea	•			
			100	/	1 /1/ 15		- 1 /			

HAZERSTOWN

DHMH 17 Rev 7/2009

State Registrar

To the Hosp within 24 hou To the Funer completed fil

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17,2011 Physician/ JOHN BRIAN PASOLA JULY12:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Birthpia-Country) D.C. Days 1 KM 2 🗆 Hours 212-76-2565 54 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28405 Kemptown Road 20872 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates Specify:White 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Automotive Body Shop Operations Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Pasola Mary Devera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Dallhan Court, Stafford, VA 22554 Diane Kerrick/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 23 Ju1y any injury or Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prostale Concer Immediate Cause (Final Pnysician Metastatic nonths disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for Month Day Year Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 N Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work? 1 Natural 5 Pending injury thin 24 hours after death the Funeral Director: At mpleted filled in by the fu Accident investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier ٥

State Registrar 31. Date filed (Month, 114

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parked

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43091

Tou House Ave, Relevich, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Leonard Putney 10:33 P M Jul v 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood . Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 10/17/1946 294-42-6450 64 Director Ohio Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Counts 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 3 Wellington Place death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates. Vietnam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Executive Director Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve Albert Benedict Putney Susan Yano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane T. Putney/ Sister 6474 Rockshire St., Alexandria, VA 22315 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 7/16/11 Edgewater, MD 4 Donation 5 Q Other (Specify) e Licensee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ 6 mon Medical resulting in death) **Examiner** Sequentially list conditions, it any leading to innectate cause. Enter Underlying Examine Due to jor as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ned by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsy death? performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 194 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For AMEND#19a per FH State 7/18/2011 AACC	State of Maryland	_	rtment of F tificate of D			giene Reg. No. 2011	24608	
Physicia Medi			Dotter N. Dotwick				2. Date of Death July 13, 2011 Year 4:35 A M				
Examiner			4a. Facility Name (if not institution, give street and number) Crofton Convalescent Center			4b. City, Town, or Location of Death Crofton 4c. County of Death Anne Arundel					
	Funeral Director		5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If U				f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 4. April 14, 1925 West Virginia				
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	,	Town or Loc	ation				10d. Inside City Limits	
			Maryland Prince 6		ie	10f. Zip Code			10g. Citizen of What Co	1 X Yes 2 □ No ountry?	
			12809 Buckingham [Lagra	20715	1- 0 : - 0 (0 -		ISA		
920			11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. 	lf If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🕅 No	n, Mexican, Puerto	o Rican, etc.)	14. Race - Ame Black, Whit		
15-0			15. Decedent's Edu (Specify only highest grad	le completed)	(Give k	ent's Usual Occup rind of work done of NOT use retired)	ation luring most of wor	king	16b. Kind of Business	Industry	
212			Elementary/Seconday (0-12)	College (1-4 or 5+) 4+	Home M				Own Home		
Maryland 21215-0036			17. Father's Name (First, Middle, Last) Gifford S. Nease				18. Mother's Nar Leta Mc		Maiden Surname)		
Man			19a. Informant's Name/Relationship (Type James C. Patrick/		le l	-			r, City or Town, State, Zi	ip Code)	
			20a. Method of Disposition 1 X Burial 2 Cremation 3 F	20h Pl	ace of Dispos	sition (Name of		Date	20c. Location - City or	r Town, State	
Baltimore,	permit. Page 1 Department of I Important: If it any injury or or		4 Donation 5 Other (Specify)		Lakemo orial	atory or other place nt Gardens	7/18		Davidsonvi		
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licenses	•					Evans Funer , MD 20715		
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Failure to Thrive, Adult Approximate Interval Between Onset a Boarth (Constant of the Constant of the								
	death certifica ne attending ph ed for use as tl		Due to (or as a consequence of): Alzheimer Dementia							3 years	
		miner	Sequentially list conditions, if any leading to himselfet cause. Enter Underlying Cause (Disease or linjury								
		dical Examiner	that initiated events resulting in death) Last	ence of):							
		edica		d							
Box 687		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No	3c. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у		23d. Date of de Month	elivery Day Year	
P.O. E			9 Unknown Part II. Other significant conditions cor	9 Unknown	Ilting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contribute to	o the cause of death?	
ds, F	v requires that s been signed k should be deta	ed by						1 🗆	Yes 2 🔀 No 3 🗆 F	Probably 4 Unknown	
SCOR	: The law cate has ; page 2	Completed						24a. Was autop		utopsy findings available completion of cause of	
al Ré		Be Co	25. Was case referred to medical			26. PI	ace of Death (Che	1 Yes		es 2 No	
Vit		은	1 L Yes 2 LA No	ospital:			4 LX Nursing F	T	lence 6 Other (Spe	cify)	
on of		Medical Certificate:	27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work M 1 🗆		28d. Describe h	ow injury occurred		
Division of Vital Records,									n (Street and Number or Rural Route Number, Town, State)		
			(Check 2 Medical Examine	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or investi	igation, in my opinio	on, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.	
			29b. Signature and title of certifier	~ 100	Tallowiougo, u	29c. License			29d. Date signed (Moni		
	14/			7 11/	20a) /T: D	D0029	571		7/13/2011		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul B. Berez, M.D. 2225E Defense Highway Crofton, MD 21114											
	State Registrar 31. Date filed (Month, Day, Year) JUL 15 2011 32. Registrar's Signature Line B. Sauke										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24609 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death RRY Physician/ LORGI 238 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb 20 1 🗆 M 2 🗷 F Hours Min. Country) Maryland **Director** 214-62-1913 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral A Bloomsbury Square 21401 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Walker Beauty Salon Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Galloway Parker Mildred Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Clark (Daughter) Hardmoore Ct. Glen Burnie, Md. 21061 Baltimore, 20a. Method of Disposition 20b. Pare (\$150) Still (\$1 ame of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Memorial Park 7 - 13 - 11Annapolis, Md. Signature of Funeral Service Licensee Winname Recese of Scilisons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final WEMIA Physician CICLT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusinan and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title Date signed (Month, Day, Year) 20/1 214

State Registrar 31. Date filed (Month, D

MOLIYU)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

15

2011

M un

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 8:00 AM Mortinan Peters Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>5730 Shadv Side_Rd</u> Churchton <u> Anne Arundel</u> 7. Age (In yrs. last birthday) If Under Hours 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 XM 2 □ F July 28 1923 Maryland **Director** 215-32-2130 87 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Tyes 2 X No Churchton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5730 Shady Side Rd. 20733 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Black Specify: 3X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. iant: If item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 1st Share Cropper Maurice Parks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Peters Annabelle Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Holland(Daughter) 5730 Shady Side Rd. Churchton, Md. 20733 20b.[H]acelof[Disposition (dame of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 7-12-11 Memorial Gardens Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee M. Marme a Resease of RecilitSons Mortuary, P.A. Zarry 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the Assease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death LUMG MITH MECASTASIS Immediate Cause (Final CANER OF Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): PANERRAS Examiner CANEEL Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ANEM (A that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 ☐ Yes 2 № No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suícide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

AUF MANES WAY, MI 1307 CHAIN FULL SE CLENSUFULE

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Box 68760

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 7 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\mathbf{Jul}^{\mathtt{Month}}$ 12 Day 201 l 3:07 P. M Kokila Dhirajlal Parikh Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 9340 Spring Water Path Jessup Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Hours Jan.14, 1936Director 75 India 146-78-6833 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Jessup 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 20794 U.S.A. 9340 Spring Water Path I Hygiene. other than "natural", or items vent, the Medical Examiner my filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 X Widowed 4 Divorced Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Chandulal Chhotalal Parikh Jashodaben C. Parikh permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9340 Spring Water Path, Jessup, Maryland 20794 Rajesh Parikh (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Balt/Wash Crematory 14 July 2011 4 Donation 5 Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Maryland 20707 23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death URRENT OVARIAN CANCER Immediate Cause (Final (Thysician/ disease or condition resulting in death) YEARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Soknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe this certificate 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes မ 2 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed ca

HOPKINS

CANCER CTK, BACTIMORE, MD 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24612 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 13, Day 2011 ear Physician/ 12:27pm R. Rolnick Philip Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8 Date of Birth **Funeral** Days Hours 1 🛛 M 2 🗆 F 101 578-07-7943 Washing ton DC Director 08/31/1909 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at the Maryland Director 1 X Yes 2 No Bethesda Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA within 72 hours after death with 5225 Pooks Hill Rd. #526S 20814 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ NoWWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail <u>Business Owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Rose Tolstoi Isadore Rosenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9907 Scotch Broom Ct.Potomac, Md. Jeanne D. Spivak-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David 20a. Method of Disposition 20c. Location - City or Town, State Falls Church VA. 1 XBurial 2 Cremation 3 Removal from State 7/15/11 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facilit Danzansky Goldberg 1170 Rockville Pike Rockville, Md. 20852 MOO910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Upper Gastrointestinal Bleed Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Blood Loss Anemia Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying Due to for as a consequence of, ending physician and use as the burial-transf Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 X No 3 Probably 4 Unknown Records, Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No this certificate Yes 2X No **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Roinicky Philip မ 1 ☐ Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29d. Date signed (Month, Day, Year) 7 / 1 3 / 1 1 29b. Signature and title of certification D71462 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd. Bethesda, Md. Dan Danila

State

Registrar

31. Date filed (Month

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Funeral		5. Social Security N 579-35-8	lumber	6. Sex 1 □ M 2 🛛	7. Ag		st birthday)	If Under 1 Year Months Days		der 24 Hrs.	8. Date of Bir	th v. Year)		9. Birth	place (State or Fore	eign
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be filed within 72 hours after death with the Maryland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by Funeral Director			ces Cou	rt				703			rog. c		salva	-	
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1 and of Hea item		20a. Method of Dis	position			20b. Pl	ace of Dispo	sition (Name of patory or other pla		1 1	Date				own, State	_
Page ment c tant: If jury or		1 <u>X</u> Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (S	3 🔀 Removal i	from State	Fan		emetery	ice)	07/23	3/2011	Sar	n Mig	uel,	El Salva	ado
permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signature of Fu	ineral Service	ognsee OMUL			₩. 32	Name and Address H. Back 47 14th	ess of Ea On F Str	unera] eet, N	L Home, W Wasi	Inc	gton,	DC :	20010	
			rt failure. List o	complications t	hat caused in each line	d the death e.									Approximate Interval Between	
Physician/ / Medical		Immediate Cause disease or condition resulting in death)	òn .	a. 40	ther	0.5C	eroti	e Car	dio	Vasci	lar 1	0,5	eas	e	Onset and Death	5
Examiner		0	174	Due	e to (or as	a conseque	ence or):									
D 34	Examiner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate erlying	D. Due	e to (or as	a conseque	ence of):									
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rtificati ing ph	Med	IF FEMALE:		00 11												
v requires that the death certific is been signed by the attending should be detached for use as	Physician/M	23b. Was decedent in the past 12 1 \(\subseteq \text{ Yes} 2		1 🔲 1	_ive Birth	of pregnar 2 Fetal at time of de	death 3	Ectopic pregnan Other (specify)	су				23d. Dat Mo	te of deliventh	ery Day Year	
the de by the ached	hysi	9 Unknown	I NO		Jnknown											
es that igned be det	2	Part II. Other signif	. /		to death b	out not resu	Ilting in the u	nderlying cause g	iven in P	art I.	23e. Did to		100		ne cause of death?	
require been s	Completed	Type	rten	51000							24a. Was		/ · 		bably 4 Unkno	
rsician: The law rs certificate has birector, page 2 sl	d l										autor perfo	osy ormed?	, c	orior to co death?	mpletion of cause	of
ian: Th	Se l	25. Was case referr	red to medical					26. F	lace of I	Death (Check	1 L Yes	2/1	No	1 L Yes	2 No	
hysic this ce al direc	2		□ No		I ☐ Inpati		R/Outpatien		4 L	Nursing Ho	me 5 Resid	dence	6 🗌 Othe	er (Specify)	
ding P. th. After t	Certificate:	27. Manner of Deat 1 Natural 2 Accident	5 Pendin	g (/	ate of inju Mo <i>nth, D</i> ay		28b. Time of injury	28c. Inju wor M 1	ryat k?]Yes 2		28d. Describe I	now inju	ary occurre	ed		
Atten er deal ector: by the		3 Suicide 4 Homicide	Investig 6 Could determ	not be 28e. P			ne, farm, stre	et, factory, office	100 2					er or Rural	Route Number,	
urs after ral Dir					uliding, etc	c. (Specify)					City or Tov	n, Stat	·e)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sompleted filled in by the funeral director, page 2 should be detached for use as the burish that the purish the funeral director.	Medical	(Check 2	Medical E	xaminer: On the	basis of e	xamination	and/or invest	ccured at the time gation, in my opini eath occurred at th	ion, deat	h occurred at	the time, date a	and plac	ce, and due	e to the car	use(s) and manner s	stated
To the within To the Comp		29b. Signature and) 1				29c. Licens					ate signed			
3		- all	w K	olires,	MI	D	ME	D3	571	97		Ju	14 1	6,	2011	_
		30. Name and addr	ess of person v	who completed	cause of d	leath (Item :	23a) (Type, P	abet 7	th.	Fran	+ F	-01	bor:	K	MAZIT	7/)
State		31. Date filed (Mont		011 2	2. Registra	ar's Signatu	ire day	1.5	-	16166	/	_ ~ ~	(0)			<u> </u>
Registra	r	JU	L202	011	-	, B.	1900									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 24614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shavndlay REZNIK July 16, Physician/ 2011 6:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth

(Month, Day Ye

Jan. 20, last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 91 **Funeral** 217-92-3184 Hours 1 🗆 M 2 🗶 F . 1920 Ukraine **Director** Jan. Usual Residence of Decedent show 10c. City, Town or Location 10b. County Examiner must be notified at Director 1 Yes 2 No Rockville 28a-f Maryland Montgomery 10f. Zip Code 20852 10e. Street and Number ö 10g. Citizen of What Country? United States Funeral 6105 Montrose Road 23a items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes Give Specify "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medicine Surgical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unknown) Meyleh Reznik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Ritchie Parkway, Rockville, MD 20852 19a. Informant's Name/Relationship (Type, Print) f Health aitem 27 i Inna Yuniver, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 and Department of Hamportant; If ite any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 07/18/11 Olney, MD 4 Donation 5 Other (Specify) 21. Si Little of Fineral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Physician/ Medical Due to (or as a consequence of): Examiner Hypertension Shayndlay, 7/10/2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 E 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Leukocytosis 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No Dehydration Division of Vital Zn. K funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Phentin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident
Suicide Investigation Q 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

only one 29b. Signature and title of cert

0100

Kimberly Zuzak, M.D., 8600 Old Georgetown Road, Bethesda, MD 31. Date filed (Month Pay, 2010 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DA46816A

29d. Date signed (Month, Day, Year)

11

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20814

		•	For State Registrar	ate of Maryla	-	rtment of He tificate of D			ene 99. N 2 0 1 1	24615
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	,	21.1			Date of Death Month	n Day Year	3. Time of Death 3:05 am
	Medic Examin	al	4a. Facility Name (if not institution, give street a	uanna U. F	kuaa	4b. City, Town, or L	Location of Death	July	15, 2011 4c. County of Dear	
	LAAIIIII		Holy Cross	Hospital			er Spring		Mo	ntgomery
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. 8		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 10	Year) 9. Bir Co 1929 Can	thplace (State or Foreign untry) Necticut
	N.		Usual Residence of Decedent 10a. State 10b. County		ity, Town or Loc	ation		Inag 10,	1727 10012	10d. Inside City Limits
	larylan 3a-f sh ified a	ecto	Maryland Montgomer		nty, 10WIT OF EGG		ckville			1 🗆 Yes 2 🕱 No
	a or 28 be not	直	10e. Street and Number	cy		10f. Zip Code		1	0g. Citizen of What Co	
	th with ms 23 must	Funeral Director	13201 Justice Ro	oad /as Decedent Ever in U	18 13 14	as Decedent of His	20853	acify Yes or No-	14. Race - Ame	S.A.
Q	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by Fi	1 Never Married 2 Married 1	rmed Forces?	If	Yes, specify Cuban Yes 2 X No	, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
-0003	ours af atural" cal Exa	Completed		Yes, Give ear or Dates.		ent's Usual Occupa		Т.	Specify: 16b. Kind of Business	White
<u>0</u>	in 72 h e. nan "n; Medi	lduc	(Specify only highest grade con		(Give k	ind of work done du NOT use retired)	uring most of worki	ing		·
77	d with Hygien ther th	Be Co	17. Father's Name (First, Middle, Last)	4		Homem	18. Mother's Name	o (Eirot Middle M		on Home
yland	should be filed within 7 and Mental Hygiene. i is marked other than raumatic event, the Me	To E		Ungiechai	er		To. Mother's Name		anie Logwi	Ln .
Mary	S S	- 7	19a. Informant's Name/Relationship (Type, Pri						City or Town, State, Zi	
e, e	의 든 없 큰		David A. Rudd - Sov 20a. Method of Disposition		5820 Place of Dispos				, Maryland 20c. Location - City or	
E	Page 1 ient of nt: If it ry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	cemetery, crem	atory or other place eaven Cem)		Silver Sp	
pairimo	permit. Page 1 and Department of Heall Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lio / se	. M0-070	22.	Name and Address	s of Facility Hin	es-Rinal	di Funeral	Home, Inc. ing, MD 20904
	### ### ###		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	u	7 111					Approximate
et l	Physician/	6 3	shock, or heart failure! List only one cause immediate Cause (Final disease or condition			t Failure				Interval Between Onset and Death Months
	Medical Examiner	Î	resulting in death)	Due to (or as a conse	quence of):					Months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	End Stay		viseuse				WORKIS
	cuted ind	Examiner	Cause (Disease or iinjury that initiated events c	Severe H		ion				Weeks
_	icate be executed physician and sthe burial transit	edical E	resulting in death) Last	Due to for as a conse	querior ory.					
09/90	tificate ng phy: as the	Medi	IF FEMALE:	-			· · · ·			
POX P	ath cert attendir for use	Physician/M	23b. Was decedent pregnant 23c. If in the past 12 months?	yes, outcome of pregrammed Live Birth 2 Fe	etal death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year
<u>.</u>	the dea by the a	hysic		Unknown	T douth 5 E					
ў. Э.	s that igned b	þ	Part II. Other significant conditions contribu	ting to death but not re	esulting in the u	nderlying cause give	en in Part I.		pacco use contribute to	o the cause of death?
Spac	require been s should	Completed	Coronary Artery D	ikaaka				24a. Was ar		utopsy findings available
Vital Records,	he law ite has	dwo	Chronic Kidney Di					autops perform 1 \sum Yes 2	y prior to	completion of cause of
Ta I	cian: T ertifica ector, p	Be C	25. Was case referred to medical				ce of Death (Chec		.,	
OT VI	Physi rthis o eral dire	은 -	1 L Yes 2 2000	1 ☑ Inpatient 2 L Ba. Date of injury	28b. Time of	28c, Injury	4 □ Nursing Ho	ome 5 Reside	ence 6 Other (Spe w injury occurred	cify)
ono	ending eath. or: Afte he fund	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1□	? Yes 2□No			
DIVISION	or Att	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	ledical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O							
	Fo the look within 2 to the look omple	×	only one) 3 Certifying Nurse Practice 29b. Signature and title of certifier	ctioner: To the best of	my knowledge, c	leath occurred at the 29c. License			cause(s) and manner as 9d. Date signed (Mons	
	5		Barbara Supa	wich REN	MD	Doc	065485	-	07/15	12011
			30. Name and address of person who comple Barbara Supanich,	eted cause of death (Ite	em 23a) (Type, P	rint)			ina Maru	land 20910
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature 2	es.	, 54	20000	- 31-3, 1100 00/	
	Registr	ar	JUL 18 2011	Leneur	13. 19 a	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jules Rever Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Funeral 7. Age (In yrs. last birthday 1 □ M 2 🖺 F Months Min. Germany Director 84 218-46-3241 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director Williamsport MD Washington 1 🗆 Yes 2 🔀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21795 Germany 16505 Virginia Ave., 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Homemaker th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mathilde Heerdegen Erich Letterer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 W. Potomac St., Williamsport, MD 21795 Karen D. Kiley / Trust Officer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematorium 107/22/2011 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each | Immediate Cause (Final disease or condition resulting in death) Pnysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be ?4 hours after death. P.O. Box 68760 s, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 1 XInpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 56023

State Registrar Date filed (Month)

tho completed cause of death (Item 23a) (Type, Print)

gistrar's Signatu

Anntai Nguyen,

MY

amend #3Per State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Hugh Leon Spitzer JulyMedical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Min (Month, Day, Ye 1 X M 2 - F 1935 Director Nov. 010-26-7560 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Montgomery Montgomere 1X Yes 2 ☐ No MD Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 USA 6403 Marywood Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 No 1959— If Yes, Give 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced 1960 than "natural", White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) kind of work done during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Biochemist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maurice G. Spitzer Mary Schiffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Marywood Road, Bethesda, Maryland 20817 Dinah Stevens Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State Parklawn Cemetery 4 Donation 5 Other (Specify) 07/07/2011 Bennington, VT Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pik Memorial Chapels Inc. e Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, P: tzer Hugh 15367077-2-11 shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Chronic Myelogenous Leukemia Ph sician/ Months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secreptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial II. and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Iniury at 28d. Describe how injury occurred Certificate: 1 🕅 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of 10 D43083 July 05, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dr. #300 Rockville, MD 20850 George 9707 Medical Sotos, M.D. State 2 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Philip D. Simon July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Montgomery

9. Birthplace (State or Foreign Country) Rockville 8. Date of Birth (Month, Day, Year) 08/10/1926 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 **X**M 2 □ F Months Hours Director Yrs 578-28-0625 Washington DC Usual Residence of Decedent 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🖁 Yes 2 🗆 No MD Montgomery Gaithersburg 5 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? 23a Funeral 60 Timber Rock Rd 20878 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 19 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1950 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify. 1952 Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. College (1-4 or 5+) Elementary/Seconday (0-12) Buver Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Moris Simon Mary Steinberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2586 Emerson Dr. Frederick, MD 21702 Gary Simo 20a. Method of Disposition Simon / 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 $oxed{2}$ Burial 2 $oxed{2}$ Cremation 3 $oxed{2}$ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/15/2011 Rockville, MD Menorah Gardens 21. Signature of Funeral Service Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 23s. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Gastro Intestinal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Perforation Duodenal Wicer Sequentially list or attione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ST. Myocardial Infarction To the Hospital or Attending Physician: The law requires that the death certificate be executed Now ST - Elevation Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No ed by the a 9 🗍 Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an autopsy perform Yes 2 has page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: ဂ္ 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year, alon 0.0 DDO 66656 13. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Ctr Rocksille MD Fakeye MD 7901 20850 Oliwapelumi 31. Date filed (Month, Day, Year)

JUL 2 0 2011 2. Registrar's Signature State

Registrar

0827

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July ^{Day} 2011 Physician/ Catherine Smith 1:50 A^{M} Avice 21 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Frederick Kline Hospice House Mt. Airy 8. Date of Birth Oct 2, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days 1 □ M 2 🛚 F Hours Mary Land 213-24-9286 85 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2X No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 U.S.A. 303 Cone Branch Drive permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 X Widowed 4 ☐ Divorced U.S.A. Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Manufacturing 12 Stitcher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Malcolm Stanley Palmer Mary Remsburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21769 303 Cone Branch Drive Middletown, Maryland Joseph Allen Smith / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 07/22/2011 Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Signature 7606 Old National Pike Boonsboro, MD at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Enter the disease, or complications or heart failure. List only one cause Approximate Interval Between 23a. Part 1 Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregpant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24620 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 7:00 P.M <u>John Carl Stonebraker</u> Julv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Broadmore Assisted Living Center Hagerstown Social Security Number 8. Date of Birth (Month, Day, 1 August 13 9. Birthplace (State or Foreign Country) Hagerstown, MD 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 93 214-09-3127 Director August Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🔀 Yes 2 🗌 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13224 Club Road 21742 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Cord Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Ribbon / Parachute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Carl Kieffer Stonebraker Helen Elizabeth McMillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Shady Oaks Dr., Kenneth C. Stonebraker / Son Franklin, NC20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 07/22/2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MICH disease or condition Medical resulting in death) **Examiner** uears Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed physician and s the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a d be detached f g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed cate has been signated to page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' hours after death.

neral Director: After this certificate I
d filled in by the funeral director, pag 2 🗌 No of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred **X** Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 7/20/20/1 Kate wishuth JW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 CRUP 1126 cpale Ct. Hagerstown, MD 21740 31. Date filed (Month, Dex State Registrar

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29c. License number 29d. Date signed (Month, Day, Year)		ne Hospii n 24 hour ne Funera pletely fill		29a. Certifier (Check only one) Lack Certifying Physics (Check only one)	ician: To the best of er: On the basis of and manner stat	f my knowledge, de examination and/or ed.	ath occurred at the tim investigation, in my op	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manr ate and place, and	ner as stated. If due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manesh Krishnamoor Huy 1110 Medical Campus Rd Ste 150 State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature A park		To t With To tl	Ž	29b. Signature and title of certifier		/	29c. License	number 0 61411	/	9d. Date signed (1	Wonth, Day, Year)
State Registrar 31. Date filed (Month, Day, Year) 32. Registra/s Signature Augus S. Aparl	IV	1-8		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	Medicali	Cambus R.	2 5to 15	o Hay	ge15+0~1 mD 21742
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death ne (First, Middle, Last, 1. Decedent's Na 3:04pm YYI Physician/ Medical Town, or Location of Death Mane Arund acility Name (if not institution, give street and number) Examiner Baltimore Washinston Medica 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min. 0272271939 MO **Funeral** Months 1 K M 2 | F 72 319-30-7607 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland Director Upper Marlboro 1 Yes 2 X No notified Prince George's 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 event, the Medical Examiner must be U.S.A. 20774 Funeral items 23a 11201 Brown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 X Married ò þ 1 ☐ Yes 2 K No Specify: Specify: White 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event: the Ma Commercial Real Estate Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname)
Edith Theodore Burgin Be 17. Father's Name (First, Middle, Last) 0 Sam Story 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11201 Brown Road, Upper Marlboro, MD 20774 Christina Story/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Clinton, MD 1 Burial 2 K Cremation 3 Removal from State 07/19/2011 Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee 8200 Jennifer Lane, Owings, MD 20736 Lisa M. Mounts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown the 23e. Did tobacco use contribute to the cause of death? ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I been signed Completed by 1 Yes 2 No 3 Probably 4 Unknown Callux page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Was autopsy performed After this certificate has 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 🗷 No ၉ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27, Manner of Death Certificate: 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier er. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practi only one To the 29d. Date signed (Month, Day, Year) 29b. Signature an

State Registrar 31. Date filed (Month, Day,

ause of death (Item 23a) (Type, Pri

32. Registrar's Signature

Dr. Glan Burnie, mp

Leeson Richardo 11-05211 Samvels **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Medical Examiner** Leeson Richardo Samuels 0630 hrs July 13, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tuxedo Road/51st street Cheverly Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Min Hours 579-21-6257 1 X M 2 F 35 Yrs Jan. 7, 1976 Country)Jamaica Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. 1 Yes 2 No Baltimore, MD 21213-UUJO
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f shu
Important: If item 27 is marked other than "natural", Montgomery Director Silver Spring 10e. Street and Number 10a. Citizen of What Country? 1102 Devere Drive 20903 Jamaica Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Yes 2 No 4 Divorced If Yes, Giva Year 1995-2002 Specify: Black 1 Yes 2 No specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Caterer Com Food Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Leeson Dudley Samuels Edna May Jemieson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna May Jemieson/Mother 1102 Devere Drive, Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) July 25 Gate of Heaven Cemeterly Donation 5 Other Specify: 2011 Silver Spring, MD 21. Signature of Funeral Service Licenses Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Gunshot Wounds of the Head and Neck Death **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and The law requires that the death certificate be executed Ca tending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by 1 be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been a 24a Was an 24b. Were autopsy findings available pnor to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural **FOUND** Subject shot 5 Pending 1 Yes 2 ✔ No Jul 13, 2011 2 0515 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City within 24 hours at To the Funeral I (Specify) Sidewalk determined 4 Momicide Tuxedo Road / 51st street, Cheverly, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 흅 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 13, 2011 el 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Dev, Yor) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

				Indelible Ink. Ensure All Copies	
			For	partment of Health and Mental Hygi ertificate of Death	ene 011 24624
	Physicia Medic		1. Decedent's Name (First, Migdle, Last) Ernest Henry Smit	2. Date of Death	
	Examin		4a. Facility Name (if not institution, give street and number) Heartland Hospice	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		9. Birthplace (State or Foreign
	Director 3		216-24-7409	Aug 1	1932 Maryland
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ctor	10a. State 10b. County 10c. City, Town or L Maryland Anne Arundel Annap		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Ma a or 28 se noti	Ä	10e. Street and Number	· ,	0g. Citizen of What Country?
	th with ms 23a must b	mera	921 Central St.	21401	USA
ဖွ	ter dea , or iter miner	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1. ▼ Yes 2 □ No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ours af atural" cal Exa	eted	3 Widowed 4 □ Divorced If Yes, Give Year or Dates 1953-55 15. Decedent's Education 16a, Dec	1 ☐ Yes 2 X No Specify: edent's Usual Occupation	Specify: Black
215	in 72 h e. nan "na Medic	guc	(Specify only highest grade completed) [Given: Elementary/Seconday (0-12) College (1-4 or 5+) life.	e kind of work done during most of working DO NOT use retired)	16b. Kind of Business Industry
	ed with Hygien Ither th	Be C	10th 0	Chauffeur 18. Mother's Name (First, Middle, Mi	Federal Government
/lan	should be filed within and Mental Hygiene. is marked other tha 'aumatic event, the N	户	William H. Smith	Marie P. Ada:	· ·
Maryland	2 shoul th and I 27 is ma trauma			lling Address (Street and Number or Rural Route Number, Control 1 St. Annanalis	
	f Healt item 2 other		20a, Method of Disposition 20b, Place of Disp	Central St. Annapolis	, MQ • Z1401 20c. Location - City or Town, State
Baltimore,	permit. Page 1 Department of Important: If is any injury or c				Crownsville, Md.
Ball	permit. Page Department Important: II any injury or			Mmane Reesee See See See See See See Mortu 1922 Forest Dr. Annapo	_
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respiratory arres	Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events		
0	be executed sician and burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):		
876	tificate ng phys as the	Medi	IE FEMALE:		
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate b 24 hours after death. Funeral Director: After this certificate has been signed by the attending physited filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medic	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
P.O.	res that the signed by do be deta		Part II. Other significant conditions contributing to death but not resulting in the		acco use contribute to the cause of death?
of Vital Records,	require been si should	Completed by	chronic obstructive puls cerebrovascular accident	L 24a. Was an	
3ec	sician: The law certificate has b irector, page 2 s	omo	Core ovas cular accident	autopsy perform	prior to completion of cause of death?
Ital	ysician: is certifica director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	Assisted
of V	g Phys er this eral dir	e: To	1 Inpatient 2 ER/Outpati 27. Manny of Death 28a. Date of injury 28b. Time	of 28c. Injury at 28d. Describe how	
ion	tending leath. or: Aftu the fun	Certificate:	1 Matural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	
Division	al or At s after o l Direct d in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 1 Medical Examiner: On the basis of examination and/or inversely only one) 1 Certifying Nurse Practioner: To the best of my knowledge	adambles is secondales de etc	
	o o o		29t/. Signature and title of certifier W	29c. License number 725	Id. Date signed (Month) Day, Year) 7 / 8 / 201/
	51		30. Name and address of person who completed cause of death (Item 23a) (Type, Lenn, fer Kiedinger 8601 Vo.)	print) 11. 112 2/105	
	Stat		31. Date filed (Month, Day, Year) 32 Registrar's Signature	- A STORY TO WITH GOVE	W 100 - 110 g
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 8, per fh, 2918 8-5-11 sm State of Maryland 7 Department of Health and Mental Hygiene for State Registrar 24625 Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Eugene Stouth 300 AM awrence 2011 Medical 4a. Facility Name (if not institution, give street and number) Çity, Town, or Location of Death 4c. County of Death **Examiner** Washin cere 12290 M 9. Birthplace (State or Foreign Count Maryland 5. Social Security Number If Under 1 dear If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Days 8/1/1923 219-14-7558 87 Yrs. Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director PA Greencastle 1 ☐ Yes 2 X No Franklin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other transments. Funeral 14918 Mercersburg Rd. 17225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer/Livestock Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Russell Stouffer Pearl Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Stouffer /Son 14766 Mercersburg RD. Greencastle, PA. 17225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 7/28/2011 Hagerstown, MD. Broadfording Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licenses 45 S. Carlisle St. Greencastle, PA. 17225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequents or, Exami and Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical The law requires that the death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months? Month Dav Year Pregnant at time of death 2 No Yes the Unknown detached 9 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 2 X No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State

Registrar

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2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\mathtt{JuLy}^{\mathsf{Month}}$ 2011 10:06 AM Rosemary Trzaska Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 12827 Kitchen House Way Germantown 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Min Oct. 30,1921 New York 1 □ M 2**X** F 89 Director 053-16-3283 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director Germantown Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 20874 12827 Kitchen House Way ural", or items 2 I Examiner mus death Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Examin 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Spencer Hamill Elizabeth Harompesta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12827 Kitchen House Way, Germantown, MD 20874 Pamela A. Trzaska (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State July 18 2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Ricenses M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Accident (Embolic) disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transif Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) ding physician Physician/Medical Type 1 Diabetes Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐XNo
9 ☐ Unknown or Month Year Other (specify) Pregnant at time of death ed f a Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Number Asthma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 😾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29d. Date signed (Month, Day, Year) title of 29b. Signature a 29c. License numbe D0057305 July 18, 2011 of person who completed cause of death (Item 23a) (Type, Print) 7 Granite Place #14, Gaithersburg, MD 20878 M.D., Janssen Jeremay 31. Date filed (Month, Day, Year State 20 2011 Registrar

		_ For	State of	of Maryland	d / Depa	artment of H	Health and N	Mental Hyg	giene 0 I	1 24627
	_	State Registrar			Cer	tificate of L	Death		Reg. No.	
Physicia		1. Decedent's Name (First, Middle, HECEN		ABET	7+	THU	INE	2. Date of Dea	th Pay 20	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,				4b. City, Town, or	r Location of Death		4c. County of D	eath
	ш	Anne Arundel Me	edical Ce	nter		Annapol			Anne A	rundel
Funeral Director		5. Social Security Number 113-26-6054	6. Sex 1 □ M 2 □ F	7. Age (In yrs. Ia 76		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/23/1	year) 934 Nev	Birthplace (State or Foreign Country) W York
d d	L	Usual Residence of Decedent 10a, State 10b, County		Inc. City	Town or Lo	cation				10d. Inside City Limits
Marylan 28a-f sh otified a	Director	Maryland Anne A	rundel_		polis					1 ☐ Yes 2 🛣 No
th the 3aor; t be no		10e. Street and Number	-			10f. Zip Code	.401		10g. Citizen of What	Country?
ath wi	Funeral	2303 River Creso		edent Ever in U.S	13.1		Ispanic Origin? (Sp	ecify Yes or No-		merican Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Beginschaft: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Marri	ed 1 Yes If Yes, Giv	orces? 2 🔀 No ve	'	f Yes, specify Cuba □ Yes 2 🛣 No	an, Mexican, Puerto	Rican, etc.)	Black, W	
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and 2 Healt tem 2 ther		Alison Cunard/Da 20a. Method of Disposition	ugnter	20b. Pl		sition (Name of	eek koau	Date Date	20c. Location - City	land 21037
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permit Depar Impor any in		1/h/	h		_ 29	973 Solom	ons Islan	nd Rd.,	Edgewater	, MD 21037
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nysici iis cei direc	10 E	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing H	ome 5 Resid	dence 6 Other (S	pecify)
th. After the funeral		27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	9	e of injury nth, Day, Year)	28b. Time of injury	wor	ryat k?]Yes 2 □ No	28d. Describe h	ow injury occurred	
to the Hospital or Attending Prystician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place	e of Injury - At ho ding, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
ospital hours auneral I	Medical (Physician: To the	best of my knowledge of examination	edge, death	occured at the time	e, date and place, a	and due to the car	use(s) and manner as	s stated. the cause(s) and manner stated
the H hin 24 the Fi	Me	only one) 3 Certifying	Nurse Practiones	To the best of my	knowledge,	death occurred at the	he time, date and pla	ace, and due to the	e cause(s) and manne	r as stated.
To Voir		29b. Signature and title of certifier	+24,	2 N 4 4	1	29c. Licens	2143	8	290. Date signed (M	7 W []
19,1		30. Name and address of person	no completed cau	use of death (Item	23a) (Type, I	TYFNCF	Hwa A	MNAPO	DUJ M D L	140/

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUL 18 2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32 Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

2 0 2011

Oak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUMPY 18, 12:00 P M Minnie WOLINCE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Chevy Chase Manor Care Chevy Chase 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔍 F (Month, Day, Year, Months 91 098-05-9390 **Director** 1920 Poland 6. lan Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Silver Spring 1 Yes 2 KNo Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a o Funeral 20902 United States 4 Saddlerock Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: white Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
New York City (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withit Department of Health and Mental Hygiens important: If item 27 is marked other the any injury or other traumatic event, the once. School System Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Yetta Goldberg David Wolince 19a. Informant's Name/Relationship (Type, Print)
David Klein, Nephew 19b Mailing Address (Street and Number or Rural Route Number City or Town, State 20015) 5715 - 26th St., NW, Washington, DC 20015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place)
Maimonides Cemetery July 20,2011 Elmont, New York 4 ☐ Donation 5 ☐ Other (Specify) une al Service Licensee Porchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Frailty Medical resulting in death) Due to (or as a consequence of): **Examiner** years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 X No Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urinary Tract Infection, Clostridium difficile 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed Decubitis Ulcer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 👿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? injury 1 XNatural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

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State

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JUL 2 0 2011

Summit Gupta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

100 First St.

Rockville,

29c. License number

Dooo8890

20851

29d. Date signed (Month, Day, Year) July 19, 2011

Please Type or Print in Black Indelibits in the Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Jonathan Ben Weiss 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) New York 1 🗶 M 2 🗆 F Months Hours Min (Month, Day, au 23. **Director** 058-44-6997 Mau Usual Residence of Decedent 28a-f show 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No Takoma Park Maryland Montaomeru 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20912 16 Philadelphia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. "natural", White Completed 3 Widowed 4-12 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Management Consulting President 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ည Gustave Weiss Eve Sapir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 E. Columbia Avenue, Falls Church, Virginia22046 Ricky Weiss - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Durial 3 Removal from State Brentwood, Maryland Lincoln Crematory: 7/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MISID 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Fatal Cardiac Arrythmia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Ventricular Fibrillation Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of and stransit Hospital or Attending Physician: The law requires that the death certificate be executed Pulseless Electrical Activity that initiated events Due to (or as a consequence of resulting in death) Last the attending physician use as the buri Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? 1 🗌 Yes 2 🗆 No I ☐ Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) funeral director Be Hospital 2 X No. Other: 1 🗌 Yes 욘 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, vessit sources a size and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar

/D

Mas

JUL 18 2011

31. Date filed (Month, Day, Year)

Miriam Lagunas-Fitta.MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

07/11/11

D68912

3001 Hospital Drive, Cheverly, Maryland 20785

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	-	For State Registrar		State	of Ma	arylan		artmei <i>rtifica</i> t			and M	∕lental Hy	/giene Reg. N	$2 \mathrm{n}$		241	631
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thin 24 the Fu	Med	(Check 2 only one) 3 29b. Signature and	Certifyin	Examiner: On the l g Nurse Practions	basis of e	best of my	n and/or inver y knowledge,	death occ	n my opinio urred at the lc. License	e time, da	ate and pla	at the time, date ce, and due to t	the cause	e(s) and due e(s) and ma ate signe	anner as s	tated.	anner state
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Baltimore, Maryland 21215-0036	Page 1 al nent of H ant: If itel ury or oth		L TYP O O O O O O - O	metery cren	sition (Name of natory or other place) NAME Zion	i	I .	Oc. Location - City or Odenton,	
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	ate be executed bhysician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C	ence of):	<u> </u>				
09	e be e ysiciar re buri	lical	d						
	rtificat ing ph s as th	Mec	IF FEMALE:						
0 x 6	ath ce attend for use	ian/	23b. Was decedent pregnant in the past 12 months? 1 Use Birth 2 Fetal 1 Pregnant at time of december 2 Pregnant at time	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
P.O. Box 687	ne dea y the a ched 1	Physician/Me	1 Yes 2 No 9 Unknown	satii J L	Other (specify)				
P.0	requires that the death certifice been signed by the attending p should be detached for use as t	by P	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause given i	in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ds,	quires en sig ould b	ted	Enlarging min	ngi	oma		1 🗆 Yes	2 □ No 3 □ F	Probably 4 Unknown
Scor	law rei has be je 2 sho	Completed	D m				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Ä	sician: The law certificate has rector, page 2		25. Was case referred to medical		Of Plans	of Death (Check	1 Tyes 2		s 2 🗆 No
/ita	rsicia s certi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	B/Outpatier	_ Other			ce 6 Other (Spe	HOSPICE
Division of Vital Records,	iding Phys th. After this funeral dir			28b. Time of injury	28c. Injury at work?		28d. Describe how		House
ivisio	after dea after dea Director	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowle only one) 3 Certifying Nurse Practioner: To the best of my	and/or inves	tigation, in my opinion, d	death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the within To the compi	Σ	only one) 3 Li Certifying Nurse Practioner: I he best of my 29b. Signature and title of certifier	w	29c. License nui		29	d. Date signed (Mont	
	2,2		30. Name and address of person who completed cause of death (Item	23a) (Ty <u>p</u> e, F	Print)	1 A		100	, - (1
			MICHAEL JULA PENTA MY	4TD	EYENSE	twy An	NAPOCI	Mnzite) [
	Sta Registra		31. Date filed (Month, Day, Year) JUL 15 2011 32. Registrar's Signati	A. A	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month IAM Medical 2011 4a. Facility Name (if not institution, give street and number)
1223 Dietrich Way Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 076-22-4980 M 2 🗆 F Days June 16, 1928 Months 83 Hours New York Yrs **Director** 28a-f show 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 1223 Dietrich Way Funeral items 23a 21409 U.S.A. within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married XX Married "natural", or þ MX Yes 2 ☐ No If Yes, Give Year or Dates. 19 Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced Specify: Completed 1951-53 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) 5+ permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Elementary/Seconday (0-12) Entrepreneur Public Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Beig ပ William Henry Wubbenhorst, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arvilla Wubbenhorst/wife 1223 Dietrich Way Annapolis, Maryland 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 7/15/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home oa 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SUBARACH NOIN Immediate Cause (Final Onset and Death Physician/ HEMURRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in doub). Let Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached to 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home FResidence 6 Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural injury 5 Pending work? Investigation 6 Could not be 2 No Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Prestioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

My X

Registrar
DHMH 17 Rev 7/2009

State

MICHAEL J.

31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

A

15 2011

11-05548 Michael Timothy Webb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 24634

State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Certific	cate of D	eath		Re	g. No.	
Physicia Iedical Examir	n/ ner	1. Decedent's Name (First, Middle, Last) Michael Timothy Webb					2. Date of Deat Month July 25, 20	Day Year)11	1305 nrs
		 Facility Name (if not institution, give street and 210 Holiday Court 	number)	1	City, Town, or Lo Innapolis	ocation of Death		4c. County of Anne Aru	
Funeral Director		5. Social Security Number 6. Sex 1217-17-1879 15. M 2 1	7. Age (In yrs. last bit	_	f Under 1 Year Months Days	If Under 24Hrs Hours Min.	8. Date of Birt		Birthplace (State or Foreign Country)
ow any	ŀ	Usual Residence of Decedent 10a. State 10b. County MD Anne Arundel	10c. City, Town	n or Location	.1d				10d. Inside City Limits 1 Yes 2 XXNo
th the Maryland 23a nr 28a-f show notified at once.	Director	10e. Street and Number 298 Ternwing Dr.			of. Zip Code	1012	10	og. Citizen of What	
MD 21215-0036 of 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a nr 28a-f she numatic event, the Medical Examiner must be notified at once	— L	11. Marital Status 12. Was I Armec 1 Ye		If Yes,	ecedent of Hispa specify Cuban, I	Mexican, Puerto		14. Race White	American Indian, Black, etc. White
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	ompleted by		rade completed) 16a e (1-4 or 5+)	Decedent's l during most	s 2 No Usual Occupation of working life. C	n (Give kind of v OO NOT use reti		16b. Kind of Bus	siness/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	E O	17. Father's Name (First, Middle, Last)		Seli	Employe 118		(First, Middle, N	MIIL Maiden Surname)	er
215. be filed nital Hy riked of cent, th	Be	Joel Ray Webb				Maria	Dowling		
MD 21 id 2 should lith and Me m 27 is ma	ဍ	19a. Informant's Name/Relationship (Type, Print) Maria Dowling Webb M	lother 2	298 Tei	nwing D	R. Arn	old, MD	21012	n, State, Zip Code)
Baltimore, MD 21215, permit. Pages I and 2 should be filed Department of Health and Mental Hy Impurtant: If item 27 is marked of injury ar other traumatic event, th		20a. Method of Disposition 1 Burial 2 XX Cremation 3 Remova 4 Donation 5 Other Specify:	I from State crema	atory or other ntic Ci	rematory	7/2		Glen Bu	City or Town, State
Balt permit. Depart Import	1	21. Signature of Funeral Service Licensee		12 1	Ridgelv	Ave. A	nnapoli	s, MD 21	Iome, P.A. 401
Physician Medical Examiner		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line. Immediate Cause (Final disease a. Proba	t caused the death. Do r	not enter the r	node of dying, si	uch as cardiac o	r respiratory arre	est, shock, or hea	rt Approximate Interval Between Onset and Death
_Xammer		or condition resulting in death) Due to (or a	s a consequence of):					0,7	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	s a consequence of):						
cuted nd transit	I Exa	dd.	s a consequence of):						
760, icate be executed physician and the burial - transit	ledical		23a,27,per		19 9-13	-11 sm		r.	
Box 68760, e death certificate be the attending physic of for use as the bur	5 I	23b. Was decedent pregnant in the past 12 months?	egnant at time of death	2 Fetal	death 3 (Specify)	Ectopic pregna	ncy	23d. Date of o	delivery Day Year
. 4 74	<u>۾</u>	Part II. Other significant conditions contributin	known g to death but not resulti	ng in the unde	erlying cause giv	en in Part I.			oute to the cause of death? Probably 4 Unknown
cords law requ has been	Completed						24a. Was a autop perfor	sy p	Vere autopsy findings available nor to completion of cause of eath? Yes 2 No
Vital Revysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?				of Death (Check			
of Vid Physic er this	의	1 Yes 2 No 28a. D	ate of Injury 28b	Outpatient 3 Time of Injur				Residence 6 v	
_ .∃ . <.∄	ation	1 X Natural 5 Pending 2 Accident Investigation	onth, Day Year)		1 Ye	es 2 No			
Division ital or Attendi urs after death. ral Director. A	Certification:		lace of Injury - At home,	farm, street, f	actory, office bui	ilding, etc.	28f. Location (S or Town, S		er or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the base and manner.	is of examination and/or	eath occurred investigation	at the time, date , in my opinion,	e and place, and death occurred a	due to the caus	and place, and di	ue to the cause(s)
• * * • * • • • • • • • • • • • • • • •	¥	29b. Signature and title of certifier , , ,	>		29c. License O.C.M			29d. Date signe July 26, 20	ed (Month, Day, Year)
Ow		30. Name and address of person who completed of Ling Li, MD Assistant Medical Ex			Street, Baltir	more, MD 21	223		
		31. Date filed (Month, Day, Year) JUL 2 8 2011	Registrar's Signature	bar	KN				

11-05530 Danny J. Whitman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

anny J. vvnitma		1-For State Certificate of Death Reg. No.
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore
Funeral Director		5. Social Security Number 577-80-8669 6. Sex 1 Nage (In yrs. last birthday) 1 Nonths Days Hours Min. Feb. 20, 1958 7. Age (In yrs. last birthday) 1 Nonths Days Hours Min. Feb. 20, 1958
and show any acc.	٥	Usual Residence of Decedent 10a. State
with the Maryland ns 23a nr 28a-f sho be notified at once.	Director	10e. Street and Number10f. Zip Code10g. Citizen of What Country?3742 Ramsey Drive21037United States
r death	by Funeral	11. Marital Status 1
5-0036 led within 72 hours afte Hygiene. ather than "natural", the Medical Examiner	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Plumber 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NDT use retired) Plumbing
21215-0036 uld be filed within 7 Mental Hygiene. marked uther than c event, the Medica	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy H. Hense 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 2 nd 2 shou ulth and M m 27 is n aumatic	٦	John E. Whitman, Srfather 197 Bunker Road Rotonda West, Florida 33947
Baltimore, MD 2 permit. Pages 1 and 2 shou Deparment of Health and N Important: Witen 27 is n injury or nuber traumatte.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 7/27/2011 Alexandria, Virginia
Bal permii Depar Impo injury		21. Signature of Funeral Service Licensee Donald W. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Md. 20705
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted 1 Insit	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of): Due to (or as a consequence of): d.
'60, rate be executed bhysician and reburial - transit	Medical	□ AMENDED 23a,pt.II,27,per me,g918 8-3-11 sm
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. I	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcohol Use 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital g Physician: free this certif	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:
F # . ~ 41	iio	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Division To the Hospital or Attendit within 24 hours after death. Tha the Funeral Director: /	Certificati	3 Suicide 4 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 ho Ta the Fune completely fi	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To Ta con	Me	29b Signature and hite of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) July 25, 2011
Ø		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Sta Regist		31. Date filed (Month, Day, Year) 32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f pr me g918,08/02/2011dhb

Registrar

State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f pr me g918,08/02/2011dhb 24636 Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Month 1713 ara July trmou Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death cultinum C altimore . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 3 Yrs. Months Min **Director** 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County Director City, Town or Location 10d. Inside City amits 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral orest 21216 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 New Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced "natural" Specify: 3 Completed lack Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ_NOT use retired) filed within 72 Elementary/Seconday (0-12) College (1-4 or 5+) edera GOVERNMENT Be ltimore, Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Page 1 and 2 should be all 0550 19a. Informant's Name/Relationship (Type, Prin , State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or () Son Kersville 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Greene Florera | Services Vaughn 1stown 23a. Part 1. Ent if 1 e disease, or con plications that caused the death. Do not enter the mode of dying, such shock, or in failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, dement 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy yes 2 No Molitension 1 Yes 25. Was cas r ferred to medical examiner?
1 X Yes 2 No Be 26. Place of Death (Check only one) Other: ျ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 X Accident 5 Pending 07/06/2011 4:00 p. M 1 Yes 2 X No Subject fell Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City or Town, State) 2921 Forest Glen Road, Baltimore, MD determined Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier JULY 18, 2011 8 D006810 mus

Registrar
DHMH 17 Rev 7/2009

State

330H

SINAI HOSPITAL OF

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

WEINTRAUS

SHARON

31. Date filed (Month, Day, Year)

2

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Pr	int in l	Black In	delible Inl	k. Ensur	e All Copie	s Are	Legible	Э.	
	•	For State Registrar	State of N	1arylan		artment of F tificate of L		d Mental Hy	giene	2011		24637
Physicia	n/	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	eath			3. Time of Death
Medic	al	Walter Irvin Al						07	28			12:55 PM
Examin		4a. Facility Name (if not institution, gi	·			4b. City, Town, or		eath	4c.	. County of De		
Funeral		<u>Iorien - Mays C</u> 5. Social Security Number 6.	Sex. 7. A	ge (In yrs. la	as <i>t birthday)</i>	Timoni If Under 1 Year	If Under 24		rth	Baltim 9.8	irthpla	ce (State or Foreign
Director		215-32-0655	Sex 7. A 1 M 2 □ F	90	Yrs.	Months Days	Hours N	1/2/1/2	71920	0 19	ountry lary	land
t ow	_	Usual Residence of Decedent 10a. State 10b. County		Tine Cit	y, Town or Loc	eation					100	I. Inside City Limits
a-f sh fied a	cto	MD Baltin	ore		aldwin	ation					100	1 ☐ Yes 2 🎛 No
or 28;	Dire	10e, Street and Number	ore .	1 100	ardw ₁₁₁	10f. Zip Code			10g. Cit	tizen of What 0	Country	/?
23a ust be	Funeral Director	4725 Sweet Air	Road			21013			_	U.S.A.		
items items items	Fun	11. Marital Status	12. Was Decedent	Ever in U.S			ispanic Origin?	(Specify Yes or No-		14. Race - Am Black, Wh		
l", or kamir	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		☐ Yes 2 X No		,		Specify: Wh		
atura cal E	etec	15. Decedent's	Year or Dates. Education		16a. Deced	ent's Usual Occup	ation		_	(ind of Busines		
e. Nedi	Completed	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or	5+)		ind of work done of NOT use retired)		working				
ygien her th		12		,	Farm	er				Self-En	plo	oyed
ntal H ed ot ever	To Be	17. Father's Name (First, Middle, Las	,					Name (First, Middle		Surname)		
mark matic	·	William Albrigh 19a. Informant's Name/Relationship			19h Mailin	a Address (Street		alena Traj		Town State	Zin Cor	40)
ulth ar 27 is 27 is r trau		Thomas Albright		ohew)		-		d - Monkto				21111
of Hear		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of patory or other place		Date		ocation - City		n, State
nage nent (ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe						8/02/2011	Lon	g Gree	n, l	Maryland
permit, rage 1 and 2 along be thought and while it is not a site beautivities with the way gain beautivity of the alth and Mental Hygiene. Insportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee									Home, P.A.
	Ц	C. J. Xa	esahn				-	d - Kings		e, Mary		
		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.					rrest,		Ir	pproximate nterval Between Inset and Death
nysician/ Medical		disease or condition resulting in death)	a. Due to (or as	/ CU		70 1,	HRIV				+-	
xaminer												
+	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	uence of):							
and transi	xar	Cause (Disease or iinjury that initiated events	c. Due to (or as	a consequ	ience off.						╄-	
ician a	alE	resulting in death) Last	Due to (or as	a consequ	derice oij.							
phys	Physician/Medical		d									
ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc	ev.			23d. Date of c	delivery	
he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ 10 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of o		Other (specify)	-7			Month	D	ay Year
d by t		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute	to the	cause of death?
signe d be c	Completed by	CONGEST	IVE H	EAR	TI	Arus	RE	1 🗆	Yes 2	A No 3 □	Proba	bly 4 🗌 Unknown
shoul	olete							24a. Was				y findings available
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rtifical	Be C	25. Was case referred to medical				26. PI	ace of Death (1 🗌 Yes Check only one)	2 N	0 101	es z	ZA NO
his ce I direc	To E	examiner? 1 Yes 2 No			ER/Outpatien	t 3 DOA Oth	er: 4 Nursir	ng Home 5 🗆 Res	idence 6	Other (Spe	ecify)	
After t	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of in (Month, D		28b. Time of injury	28c. Injur work	?	28d. Describe	how injur	y occurred		
death ctor: , y the	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	be 280 Place of Ir	iurv - At ho	ome, farm, stre	M 1 🗆	Yes 2 No	28f. Location	Street an	d Number or F	Rural R	oute Number.
s after I Dire		4 ∐ Homicide determine		tc. (Specify		,		City or To				
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		nysician: To the best of miner: On the basis of									e(s) and manner stated.
thin 24	Me	only one) 3 Certifying N	urse Practioner: To th			eath occurred at th	e time, date and		he cause(s	s) and manner	as state	ed.
. 1 ₩ 00		29b. Signature and title of certifier	me (2	0	29c. Licenso		44	29a. Da	te signed (Mor	itri, Da	y, rear)
		30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	rint)	795	/ /	0.	1/0	0/	00//
		Susan Am	Tropy	670,	1 ~5,	CHARL	E5 5	T 81E	410	5 70	28	on, m
Stat		31. Date filed (Month, Day, Year) -	- 32. Togisi	rar's Signa	ture	Red					2	1204

DHMH 17 Rev 7/2009

Registrar

AUG 0 3 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24638 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jul 29, 2011 Year Anna Marie Appler 1:54 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Columbia Howard Gilchrist Hospice of Howard County If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F (Month, Day Year) Nov 14, 1920 Country 213-16-1371 PA Director Usual Residence of Decedent 28a-f show 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified MD Howard **Ellicott City** 1 ☐ Yes 2 No 10e. Street and Number ō 10f. Zin Code 10g. Citizen of What Country? 23a Funeral 9814 Michael's Way 21042 U.S.A. "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Single Anna Lasko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 9814 Michael's Way Ellicott City, MD 21042 Robert Appler spose 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Degrial 2 Cremation 3 Removal from State St. Alphonsus Church Cemetery Aug 02, 2011 Woodstock, MD Donation 5 Other (Spec e of Finery Service 22. Name Sid Archineral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 1200535 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between diate Cause (Final Onset and Death Physician/ disease or condition 2010 Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last /sician a burial-i Physician/Medical phys the b A se e IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death a I Inknown Be Completed by ဂ

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director: within 24 hours after dear To the Funeral Director completed filled in by the

Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
DIABETES				1 🗆 Yes 2	XNo 3 Probably 4 Unknown
CHRONIC KION	TERY DISEA	SE EASE		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of Death (Che	eck only one)	WOODS PACKS - CORDS - MEDIC - TO SEE
examiner? 1 Yes 2 No	spital:	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence 6	X Other (Specify) HOSFICE
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
	ian: To the best of my know r: On the basis of examinatio				d manner as stated. and due to the cause(s) and manner stated

State Registrar

Certificate:

Medical

only one)

29b. Signature and title

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated JULY 29, 2011

30. Name and address of person who completed ca death (Item 23a) (Type, Print) DOBERMANINO DANIEUE

CEDAL LANE COLUMBIA, MD 21044

1 - State of Maryland / Department of Health and Mental Hygiene per me, g918,08/02/2011dhb Certificate of Death 24639 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Ann Mary Brown Day 11:05_AM 201°1 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford County Upper Chesapeake Medical Center Bel Air . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days 1 M 2 X F Hours 217-18-4036 12/27/1921 Country)
Maryland 89 Director Usual Residence of Decedent 28a-f shov 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Abingdon Maryland Harford County 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 21009 Funeral 2719 Merrick Way United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Keeping Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Frank Orbin Helen Cheponis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important If item 27 is any injury or other trausonce. Carolyn Tosh (Daughter) 2051 Stratton Court, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 07/12/2011 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gdns. 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Qnset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit CERTIFICATION APPROVED BY HEDICAL EXAM Brown, Ary and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Inknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas 4800215039 autopsy After this certificate I 2 No Yes P 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မြ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending thin 24 hours after death.

the Funeral Director: All impleted filled in by the fu death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier -Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one 29b. Signatu 29d. Date signed (Month, Day, Year) ρ D0056296 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 500 Upper Chesapeake Dr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- State Amend Item Registrar	25 per me,	g917,	67/29 Cer	72011dhb tificate of t	Death	ı menta	u ⊓ygi R∈	ene eg. Na 2 (24640
	Di	.,	1. Decedent's Name (First, Middle, La.	st)						e of Death	١		3. Time of Death
	Physicia Medic		Marilyn Lee Barre	tt				-	Jul	y 6,	2011	Year	6:00 A ^M
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location of De	eath		4c. Coun	ty of Death	1
- /	, 		Manor Care Potoma				Potomac				Mont	gomer	У
	Funeral Director		5. Social Security Number 6. S 007–36–0510	ex	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		in. (Mo	e of Birth Inth, Day, ber 18	Year) 3, 1937		nplace (State or Foreign Intry) .ne
	D wo		Usual Residence of Decedent 10a. State 10b. County		10- 02- 7								40.11.11.09.15-5
	yland -f sh ed a	당	,		10c. City, T	own or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	ath w	nne	6607 Elgin Lane 11. Marital Status	12. Was Decedent Ev	ver in IIS	13 \	20817 Was Decedent of H	ispanic Origin?	(Specify Vos		Inited		es ican Indian,
'	or ite	by F	1 Never Married 2 Married	Armed Forces?			f Yes, specify Cuba					ack, White	
ဗ္ဗ	s afte ral", Exan	q p	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	40	1	I ☐ Yes 2 🗶 No	Specify:			Speci	^{fy:} Whi	te
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yla	Ild be Ment arke	ř	Cecil Lee					Bernade	tte M	cQuad	le		
Jar	shou and is r		19a. Informant's Name/Relationship (1	-			ng Address (Street				-		
<u>~</u>	and 2 lealth im 27 her t		Amanda Barrett/Da	ughter			Elgin La	ne, Bet					
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	J	21. Signature of Funeral Service Licen	11 14	1530	R6	Name and Address bert A. Pun 57 Wiscons	iphrey Fu in Avenue	neral H	ome, I	Bethesda Marylan	a-Chev	y Chase, Inc. 4
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₹			27. Manner of Death	28a. Date of injury		Bb. Time of injury	28c. Injury work	:?	28d. De	scribe hov	v injury occu	ırredi	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Bernard Gladys 2011 Medical 08 3:59p 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchirst Hospice Towson 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 😿 F 215-24-7709 **Director** 82 16 MD 06 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director notified Baltimore 1 Kes 2 No MD NA 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a Funeral filed within 72 hours after death with 21207 U.S.A. 3501 Hillsmere Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 🗆 Widowed 4 🔀 Divorced Specify: Black "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Social Security Adm grade Claims Examiner na traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Odessa Owens Randolph Monahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Lloyd Bernard-Son 2001 Middleborough Road, Essex, Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or Department of Important: If 4 Donation 5 Other (Specify) 8/5/32011 Memorial Arbutus, Ferenal Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av once any 21215 Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Interval Between Onset and Death Ph sician/ TAGE ENAL disease or condition OMES Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 mon for Month Day Year signed by the at be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 2 PERTENSION Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been PEZ DIABOYES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed certificate 1 Yes **Division of Vital** • Hospital or Attending Physician: 24 hours after death. • Funeral Director, After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ithin 2 the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D4636

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

31. Date filed (Month, Day,

AUG 03

8601 NORTH CHARLES.

address of person who completed cause of death (Item 23a) (Type, Print)

Randol ph Brown 8760

		State of Maryland / Department of Health and Mental Hygiene 1 - State State Registrar Certificate of Death Reg. 2011 24642								
			Registrar 1. Decedent's Name (First, Middle, Last)	incate of Beath	2. Date of Death					
	Physicia Medio		Randolph	Brown	Month O7	Day 2011	2:00a. M			
Examine			4a. Facility Name (if not institution, give street and Ivy Hall Nursing H		4b. City, Town, or Location of Death Middle Rive	r	4c. County of Deat Balt:	altimore		
	1 SPM 2 F			7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 09 18	9. Birthplace (State or Foreig Country) NC			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	246-52-9215 XWZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ	70		109 16	34	NC		
			10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits		
		ire	MD NA	Balti				1X Yes 2 ☐ No		
		Funeral Director	10e. Street and Number		10f. Zip Code 21215	109	g. Citizen of What Co U • S • A			
		nue	1716 Ingram Road 11. Marital Status 12. Was Decedent Ever in U.S		Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	rican Indian,			
9		by F	Arme	ed Forces?	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.		
21215-0036	ursaff :ural", al Exa	ted	3 □ Widowed 4 🔀 Divorced Year	s, Give 1 or Dates.	Yes 2X No Specify:		Specify: B	lack		
15-	72 hoi n"nat ledica	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give i	dent's Usual Occupation kind of work done during most of work	king 16	6b. Kind of Business	Industry		
12	ithin iene.	Con	Elementary/Seconday (0-12) Colle 9th grade n	ge (1-4 or 5+)	o NOT use retired) ne Worker	c:	leaner H	angers co.		
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Maryland	should be fi and Mental is marked raumatic ev	오	Claude Brown		Lossie	Kenlaw				
Nar			19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rui					
e, 1	and 2 Health em 2; ther t		Linda Brown-Daught 20a. Method of Disposition	er 1716			Oc. Location - City or			
nor	tge 1 and the first transfer of transfer of transfer of transfer of transfer of transfer		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery, cren	natory or other place)		Woodlawn			
Baltimore,	mit. P.		21. Squature of Moreral Service Licensee	King Mem	orial Park 8/9 Name and Address of Facility arch F/H West	/2011 1	NOOGLAWII	, rid		
ä	permir Depar Impor any in		1 SANTON X	naham M	arch F/H West 300 Wabash Ave	Balti	more, MD	21215		
)	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between		
-me_	Physician/		Immediate Cause (Final disease or condition	ETASTATIC F	PROSPATE CANCE	2		Onset and Death		
	ate be executed physician and the burial-transit		resulting in death) Due to (or as a consequence of):							
		er	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of):	Truenuls					
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		dical Examiner	that initiated events c. Due to (or as a consequence of):							
9		dica	d			-				
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Box	atten atten I for u	iciar	in the past 12 months?	Live Birth 2 Fetal death 3 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month			
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of Vital Records,	The law requires the law requirements th					24b. Were autopsy findings available prior to completion of cause of death?				
R	ician: The la certificate ha rector, page		25. Was case referred to medical			1 Yes 2		s 2 🔀 No		
/ita	ysician: iis certific director,	o Be	examiner? 1 Yes 2 No	1 Inpatient 2 ER/Outpatier	26. Place of Death (Chec		0 Dother (Care	is a		
of/	ding Phys h. After this funeral di	e: To	27. Manner of Death 28a.	Date of injury 28b. Time of	28c. Injury at	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
O	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	ficat	2 Accident Investigation	(Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No					
Division		Certificate:		Place of Injury - At home, farm, strebuilding, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	pital o									
Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and						at the time, date and	cause(s) and manner stated.			
	To the within 2 To the comple	2	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day,						
) July	PHYSICAN n	MD 00064556	3	08/02/3	eal		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONY VARGHESE 821. N. GWAW T. SUIE 308 PARTMONE WD							
	Stat	24 Date Siled (March Day Veer)						w 10-10 -(D		
	Registra		AUG U 3 2011 2	un S. Sark				:		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24643 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BROWN 8:30 PM EBORAH 2011 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Prince George's Laurel Regional Hospital Laure 5. Social Security Number 8. Date of Birth (Month, Day, Y June 28 6. Sex Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Months Days Hours 578-68-4521 60 DC **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other trainer. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Prince George's Beltsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20705 7108 Sequoia Terrace USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 No 3 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James K. Brown Dora Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 546 Nicholson Street, Washington, DC 20011 Ingrid Brown/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 08/06/2011 Riverdale,MD 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Figneral Service Licensee 7474 Landover Road, Landover, Maryland 20785 23a. Part 1 Enter the shock, or hear Immediate Cause 6 disease or condition sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Respiratory Medical resulting in death) Examiner Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Esophageal Candidiasis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 XNo 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title D55861 w Dusen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Laurel Regional Munim, Hospital MD

DHMH 17 Rev 7/2009

State Registrar

			1 - State Registrar Certificate of Death Reg. No.												
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of			ate of Dea				3. Time of Death	
Medie Examir		cal	Suzelle M. Bevers							lly 28	$\overline{}$	2011 Year		8:45 A M	_
		ier	4a. Facility Name (if not institution, give street and number) 849 Derby Farm Dr.				4b. City, Town, or Location of Death Severn				4c. County of Death Anne Arunde1				
	Funeral Director		5. Social Security Number 578–46–3006 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthday) 74 74 75.				Inder 1 Year oths Days	If Under 24 I Hours N		Date of Birti Month, Day	h 3	9. E 1936 Was	lirthplac Sountry) Shir	e (State or Foreign	С
90036	nd thow at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Towi	n or Location							10d.	Inside City Limits	_
	Maryla :8a-f s tiffied		Maryland Anne Aru	ndel	Glen B	urnie								1 Yes 2x No	þ
	with the I		10e. Street and Number 1011 Cayer Drive				10f. Zip Code 21061				10g. Citizen of What Country? United States				
	death items		11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was D	ecedent of Hi specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Y	es or No-		14. Race - An Black, Wh			_
	urs after :ural", or al Exami	ted by	1 Never Married 2 Married 3 Widowed 4 X Divorced	1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates.	0		es 2 🛭 No			, ,		Specify: Wh			
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nd	e filed ttal Hy ed oth event		17. Father's Name (First, Middle, Last)					18. Mother's	·			Surname)			
2	ould by mark mark		Joseph Blanford (105	Mailian Ada	dua == (Odua =d	Mildre			_	r Town, State, 2	7:- O-d	-1	50
, M a	nd 2 sh ealth ar m 27 is ner trau		19a Informant's Name/Relationship (Information B. Francisco Lisa B. Francisco	/ Daughte								1and 21		e) 	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☒ Other (Speci	fy)Entombmen		ry, crematory wridge	or other place Mem.	Pk.	gust 2011		E1k	ocation - City o	Maı	yland	
Ba	Depar Impor any ir		21. Signature diffuneral Shuice Licen	see		22. Nam Kirl 421	e and Addres Ley-Ru Crain	s of Facility iddick Hwy.,	Funer S.E.,	al Ho	ome, n Bu	P.A. irnie, l	MD 2	21061	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
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8760	± 5, a	Med	IF FEMALE:									-			_
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O	requires that the death been signed by the atte should be detached for	by	23e, Did							tobacco use contribute to the cause of death?					
rds	require been si hould	eted							_					ly 4 Unknown	_
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<u>Ita</u>	sician: The certificate irector, pag	m	25. Was case referred to medical examiner?	Hospital:			Othe	ace of Death (C				. Maria	1	laughter† lome	S
5	ng Phy ter this neral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day,		itpatient 3 L Time of njury	28c. Injury work	at at				Other (Spery)	ecity) I	TOME	_
ion	death. tor: Af	Certificate:	1X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 🗆	Yes 2 No							_
	tal or A s after al Direct ed in by	_	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				стогу, описе	ory, office 28f. Location (Street and Number or Rural Route City or Town, State)					ute Number,		
	To the Hospital or Attending Physician: " within 24 hours after death or To the Funeral Director: After this certification pleted filled in by the funeral director, it	Medical	(Check 2 Medical Exam	sician: To the best of m iner: On the basis of exa se Practioner: To the be	mination and/o	r investigation	n, in my opinic	n, death occurr	red at the tir	me, date ar	nd place	e, and due to the	e cause(d.
	Voith with Coal		29b. Signature and title of certifier 29c. License number 29d. Date signed (No. 1) July 28,												
			30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type, Print)						J ,			_
			Elliott Gorbaty,	M.D., 141	l Madis		ck Driv	re, Gle	n Bur	nie,	Mar	yland	2106	51	_
	Stat Registra	e ar	31. Date filed (Month, Day, Year) AUG 0 2 2011	32-Registrar	s Signat <u>ure</u>	excel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State O' State Registrar	f Maryland / De <i>C</i>	epartment of H Certificate of L			2011	24645
Physicia	n	Decedent's Name (First, Middle, Last)	200KS	3		2. Date of Death Month	Day Year 08 2011	3. Time of Death
/Medica Examine	r	4a. Facility Name (If not institution, give street and nur MANOR CARE Dulaney	TOWSON		USONIN	8. Date of Birth	4c. County of Death	1
Funeral Director		5. Social Security Number 212-07-7534 Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Days	Hours Min.	ec 31, 1	913	intry) Lrginia
Maryland f show led at		10a. State 10b. County MD Baltimore	10c. City, Town o	r Location				10d. Inside City Limits 1 □ Yes 2 No
with the I	al Director	10e. Street and Number 8347 Mindale Circle #C		10f. Zip Code 21244		100	g. Citizen of What Cou USA	untry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentall Hygiene. The ZT is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deccarred Armed For 1 □ Yes If Yes, Girly Year or Divorced	2Ã No ve l	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2【 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: b	
within 72 hou liene. Than "naturathe Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (12)		ecedent's Usual Occupa Give kind of work done of the DO NOT use retired bookkeeper	luring most of workir		6b. Kind of Business/I	ndustry unk
Vial y all of a 12.1. 12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) William Thomas Mercer			18. Mother's Name Sallie	(First, Middle, Ma	*	
e, INICALY Tand 2 sho Health and Pen 27 is ma ther trauma		19a. Informant's Name/Relationship (Type. Print) Lloyd G. Johnson Jr -		Mailing Address (Street a 2906 Whitney	y Ave; Ba	ltimore,	Maryland	21215
parimit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☒ Donation 5 ☐ Other (Specify)	cemeterv	isposition (Name of crematory or other plac	e)		0c. Location - City or	Town, State
permit. Departr Imports any inj		21. Signature of Euneral Service Licensee	Director		altimore	St; Balt	imore, MD	21201
Physician /Medical Examiner	Je.		caused the death. Do not peach line. RERROV (or as a consequence of)	/AScul	g, such as cardiac o	crespiratory arres	2NT	Approximate Interval Between Onset and Death
physicial physicial the burner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to	(or as a consequence of)	т.	-			
the death certi	Physician/M	in the past 12 months?	tcome pf pregnancy birth 2 Fetal death nant at time of death nown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of del Month	ivery Day Year
v requires that been signed by should be deta	کر ا	Part II. Other significant conditions contributing to de HYRERTENS DN,	eath but not resulting in the	he underlying cause give	en in Part I. アビ	23e. Did toba	acco use contribute to s 2 No 3 □ Pr	the cause of death?
The law recate has bee	Completed	Disease				24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of 2□ No
Attending Physician: The law requires that the death certific roteam. ctor After this certificate has been signed by the attending pet the funeral director, page 2 should be detached for use as	To Be	27. Manner of Death 28a. Date	Inpatient 2 ER/Outp. of Injury nth, Day Year) 28b. Tin	me of 28c. Injur	400 Nursing Ho		nce 6 □Other (Spe	cify)
To the Hospital "r Attending Within 24 hours a led deam. To the Funeral Lirector After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	e of injury - At home, farm ling, etc. <i>(Specify)</i>	n, street, factory, office		28f. Location (Str City or Town,	eet and Number or Ro State)	ural Route Number,
To the Hospital or within 24 hours are To the Funeral Directory completely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the land man						
To t withi To th	Σ	29b. Signature and title of certifier Eric Anapolicus	1, CRNP	29c. Licens R 15			7/26/2	
		30. Name and address of person who completed cau ERIC A NA POLSKY. CRUP 31. Date filed (Month, Day, Year) AUG 0 3 2011	se of death (Item 23a) (T	ype, Print) ARSHALEE	DR. EL	KRIDE	E, MD	21075
Sta Registr	te ar	31. Date filed (Month, Day, Year) 2011	registrar's Signature	arked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month July 201°1 5:35 rainia Ам W. Boggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Devlin Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days March 29 ^{Year)}191<u>8</u> 1 □ M 2 🗓 F Maryland Director 93 214-05-9976 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Allegany Cumber land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 10301 Christie Rd. 21502 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Mary Mittinberger Margurad William Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11319 DeHaven Rd; Cumberland, Maryland 21502 Edna Pesarcik - friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) ignatur Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGERTIVE Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confident has a continuation of the funeral Director. and I-transit that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician s should be detached for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 No Linknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Others 힏 1 🗌 Yes 2 🔽 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 5 Pending work' 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Harjit S. Sidhu

AUG 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) 26 907

625 Bishop Walsh Road Cumberland, Maryland 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per inf g918 8-9-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month SA 5:00 P. M. 1 1 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4410 EVAMAY ROAD, BALTIMORE #1A BALTIMORE ocial Security Number 9. Birthplace (State or Foreign Country).
UKRAINE If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth **216-**-25-8629 1 □ M 2 🛛 F Months Hours Min 1272571913 **Director** 97 Usual Residence of Decedent 28a-f shov items 23a or 28a-t snoner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4410 EVAMAY ROAD, #1A 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumation. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CHEMICAL ENGINEER ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ BEYLIS BASYA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 EVAMAY ROAD, #1A, BALTIMORE, MD 21215 BORIS ZISMAN / SON 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ARI INGTON CEMETERY
CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/02/2011 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Nass 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) 30 YR7 VD Medical Examiner Yes Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death Unknown bed the Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ L) BREATT LCINOMA Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autops certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes Other: 욘 1 Inpatient 2 I ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Detrifying Physician is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) MAFFEZZOZ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Year July Bhalla 30. Sohan 7:20 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Towson Baltimore Greater Baltimore Medical Cente Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 💢 M 2 🗆 F Days Hours AUg 30 Year 913 212-80-8287 Pakits tan 97 Director Usual Residence of Decedent 10a. State 10b County 10d. Inside City Limits 28a-f shov 10c City Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛭 No Parkville Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 3417 North Trail Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Aviation Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marken any injury or care. and Mental F ည Duggal Bhalla Sudha Chand L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Maryland 3417 North Trail Way Swadesh Bhalla Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 8-1-2011 Maryland ☐ Donation 5 ☐ Other (Specify) Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pheh monta spiration disease or condition Medical resulting in death) r as a consequence of **Examiner** insufficiency Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 30 disease nr Alberoscleretie the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last 40 Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown has been sig e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? defreiency Iron 24a, Was an autopsy page performed Protein mal hutrotien certificate Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Tes 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director. A completed filled in by the fu Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

only one) 29b. Signature

Stephen

31. Date filed (Month

- Smith

3 2011

AUG 0

8709 Harford

thy sie fan

ess of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

7-31-11

Baltimores, Ada

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd #14 Per FH G929 7/13/2012 Jh
State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month JUL Year Physician/ Cowlina ivingston 23 18 2011 Medical cility Name (if not institution, give street and number) 4b. City, Town, or 4c. County of Death Examiner HOWARD If Under 8. Date of Birth Bathplace (State or Foreign (In vrs. last birthda **Funeral** Months Days **Director** 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status American Indian Examiner BNatrive American 1 Never Married 2 Married 6 þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🚾 No Specify: "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working timore and Mental Hygiene. College (1-4 or 5+) se retired) Elementary/Seconday (0-12) Be permit. Page 1 and 2 should be filed. Department of Health and Mental Humportant: If item 27 is menum injury or other. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Su ပ္ Informant's Name/R ationship (Type, Print) te, Zip Code) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Methol of Disposition

1 Seurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City of Town, State 4 Donation 5 Other (Specify) Signature of Fun-ral Service Licensee de 4013 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Shock Septic hours disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner ditticile Clostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Multiple 3 months Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit myelomo and Due to (or as a consequence of): attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an mellitus page 2 s has performe hemodialysis certificate 1 Yes 2 No on 25. Was case referred to medical completed filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67322 JUL 30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MD 5755 Cedar Lane Johns Physicians MD Hopkins Community Bansal 0 3 2011 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of N Registrar	Maryland / Depa <i>Cer</i>	artment of He <i>tificate of De</i>			ene g. N2011	24650
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
* ~	Medic Examin	al	David D. 4a. Facility Name (if not institution, give street and number)	Collett, St	4b. City, Town, or Lo	ocation of Death	August	1, 2011 4c. County of Dea	8:03 a M
-	LAGIIII		3222 Niner Road		Finksbu	rg		Carr	
	Funeral Director		216-72-8860 1 ☑ M 2 ☐ F	Age (In yrs. last birthday) 54 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) May I,	1957 g. Bi	irthplace (State or Foreign ountry) laryland
	and show	ē	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryl 28a-f notifie	Director	MD Carroll	Finkb					1 ☐ Yes 2 🕱 No
	with the 23a or ist be r		10e. Street and Number 3222 Niner Road		10f. Zip Code	1048	10	og. Citizen of What C U.S.A	
	death y	Funeral	11. Marital Status 12. Was Decedent Armed Forces	?	Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
036	rs after Iral", or Exami	ed by	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	₫ No 1	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
15-0	72 hou n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give F	dent's Usual Occupation	on ing most of work	ing 1	6b. Kind of Business	s Industry
212	within giene. ier thai		Elementary/Seconday (0-12) College (1-4 or 12)	5+) IIIe. DC	O NOT use retired) Plumber			Plumbi	ing
and	be filed intal Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last)		18	8. Mother's Nam Caro1	e (First, Middle, Ma J •	aiden Surname) Loosmore	Α.
anyl	hould k and Me is mark		Richard Candido Po	orta 19b. Mailin	ng Address (Street and				
ē,	and 2 s Health s em 27 i her tra		Sharon Collett Wife 20a. Method of Disposition		Buckinghan		Gwynn Oa		1207
mor	Page 1 arent of H		1 Burial 2 Cremation 3 Removal from Stat 4 Donation 5 Other (Specify)	te 20b. Place of Disposer cemetery, crem Mt Olive	natory or other place)	8/5/	l l	:0c. Location - City o Randallst	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licensee	. V. 22	. Name and Address of	of Facility 118	24 Reiste	erstown Ro	oad
	1111111		23a. Part 1. Enter the disease, or complications that cause	ed the death. Do not ente	JINE FUNERA	AL HOME	Reister	stown, MD	21136 Approximate
-~-	Physician/	1		osuleiolic	Corse.	·y V	and b	2,5000	Interval Between Onset and Death
and the	Medical Examiner			s a consequence of):					
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as Cause. Enter Underlying Cause (Disease or linjury	s a consequence of):				Ų.	
3	icate be executed I physician and s the burial-transit	l Exa	that initiated events c.	s a consequence of):	-				
09/	ate be physicii the bu	edical	d						
Box 68760	certific ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom	e of pregnancy	Estania programa			23d. Date of de	elivery
. Bo	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M		at time of death 5	Other (specify)			Month	Day Year
Division of Vital Records, P.O.	res that t signed b	by	Part II. Other significant conditions contributing to death	but not resulting in the un	nderlying cause given	in Part I.			o the cause of death?
ord	v requii s been s should	Completed					24a. Was an	24b. Were a	utopsy findings available
Rec	The lar	Com					autopsy performe 1 Yes 2	ed? death?	completion of cause of
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other	of Death (Check			
of o	ng Phy ter this neral d	ite: To	27. Manne of Death 1 Natural 5 Pending (Month, D	jury 28b. Time of injury	28c. Injury at work?		ome 5 Residen 28d. Describe how	ce 6 Other (Spering Injury occurred	cify)
sion	ttendii death. stor: Af / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	njury - At home, farm, stre	M 1 🗆 Yes	s 2 🗆 No	006 1 01: /04	at and Number of D	and Davide Abreation
Divi	ital or A		4 - Horricide determined building, e	etc. (Specify)			City or Town,		
	e Hosp 124 hou e Funer	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner; On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or invest	tigation, in my opinion, o	death occurred at	t the time, date and	place, and due to the	cause(s) and manner stated.
	To th Vithir Comp	2	29b. Signature and title of certifier 1. 12. 12.		29c. License nu		290	d. Date signed (Mont	
			30. Name and address of person who completed cause of	death (Item 23a) (Time D	brind)			0/1/2	1/
	Ve		Robert L. Moss, M.D	114 Busine	ess Cent	er Dr	. Reis!	terstown	1, MD 21136
	Stat Registra		31. Date filed (Month, Day, Year) 32. Regist	trar's Signature					,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / De	partment of Health and N 02/2011dhb Crifficate of Death	ental Hygie Reg.	2011 24651
Physici /Medic		1. Decedent's Name (First, Middle, Last)	4b. City, Town, or Location of Death	July 2	Day Year 2011 1.12 PM 4c. County of Death
Examin	er	4a. Facility Name (if not institution, give street and number) The Johns Hopkins Hospital 5. Social Sesurity Number 6. Sex 7. Age (In yrs. last birthda	Baltimore City		N/A
Funeral Director		212—28—2298 1 M 2 XF 79 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March3,	1932 Maryland
Maryland a-f show iied at	ctor	10a. State 10b. County 10c. City, Town or N/A	Location Baltimore		10d. Inside City Limits 1 1 Yes 2 □ No
with the 3a or 28a	al Director	10e. Street and Number 2404 McElderry St.	10f. Zip-Code 21205	10g.	Citizen of What Country? USA
VIAING ZIZIS-UUSO Void be filed within 72 hours after death with the Manyland Mental Hygiene. Brited other than "natural", or items 23a or 28a-f show after other than "natural", or items 2be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes XXo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Z I Z I 3-0036 cd within 72 hours aft giene. er than "natural", or the Medical Examir	Completed b	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired)	ring	b. Kind of Business/Industry
ITYIANG Z1Z should be filed withir nd Mental Hygiene. marked other than matic event, the Me	Be Com	12th Grade 17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	Lawyer's Office iden Surname)
Mar d 2 sho th and :7 is ma trauma	면	Moses Holmes 19a. Informant's Name/Relationship (Type. Print) Husband Melvin Cornelius, Jr. 240	Victo: ulling Address (Street and Number or Ru 4 McElderry St.	ral Route Number. C	ity or Town, State, Zip Code) re, MD 21205
Datumore, M permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra		PEPBUNA E OF CHARGOT O TOTAL TOTAL CLARGE	rematory or other place) n Cemetery 7/7	/11 В	c. Location - City or Town, State
beautimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	4210 Belair Roa	d Baltim	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
cate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c	Pamela CERTIFICATION	APPROVED BY MEDIC	MD AL EXAMINER
eath certific attending p	Physician/Me		B		23d. Date of delivery Month Day Year
us, F.C. ires that the d signed by the Id be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 X No 3 - Probably 4 - Unknown
or Attending Physician: The law requires that of Additional Physicians. The law requires that offer death. The function additional has been signed in by the funeral director, page 2 should be contained.	Completed			24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \sum No
nysician: Th nysician: Th nis certificate	To Be (25. Was case referred to medical examiner? 1 XX Yes 2 \sum No Hospital: 1 XX Inpatient 2 \sum ER/Outpat	ient 3 DOA Other: 4 Nursing Ho		e 6 □ Other (Specify)
To the Hospital or Attending Physician: The Inviting 4 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 □ Natural 5 □ Pending investigation 2 ☑ Accident 3 □ Suicide 4 □ Homicide 28a. Date of Injury (Month, Day Year) 28b. Tim Inju 28b. Tim (Month, Day Year) 28b. Tim Inju 28c. Place of Injury - At home, farm, building, etc. (Specify)	y Work? 1 ☐ Yes 2√7 No	28d. Describe how 28f. Location (Street City or Town, S	Sed fall in kitchen et and Number or Rural Route Number,
Hospital o 24 hours aft Funeral Dii etely filled in	edical Cer	29a. Certifier (check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/o and manner stated.	ath occurred at the time, date and place		se(s) and manner as stated.
To the within To the compl	Me	29b. Signature and title of certifier Voltage Livelite Miles	29c. License number	29d.	Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	North Wolfe	e St, Baltimore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) 2. Begistrar's Signature	Med		

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24652 1- State Registrar Amend Items 25 per me, g918, 08/07/2015 Indeath 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 122M 2611 une 28 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number MM 2 F Days Hours 223-38-177 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No NDHone 10g. Citizen of What Country? 10e. Street and NO 10f. Zip-Code 20724 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT the retired) (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1 College (1-4 or 5+) Mechanic er's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) hine per or Plural Route Number, City or Town, State, Zip Cod 1046 111 Rd, Apt. 538, Columbia, MD 19a. Informant's Name/Relationship (Type. Claughter omai Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory) or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 7 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumenia disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): CERTIFICATIO IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an

Physician /Medical Examiner

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2 should be detached

been signed by the

certificate has I page

filled in by the funeral director,

after death.

within 24 hours

attending physician

The law requires that the death certificate be executed

Physician:

or Attending

the

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Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

Examiner

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'natural",

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

filed within 72 hours after death with the Maryland

21215-0036

Maryland

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

26. Place of Death (Check only one) 3 🗆 DOA 2 ER/Outpatient

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗌 No 1 Yes 1 Yes

Yes ZXIVO Hospital: 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 5 Pending investigation Injury

Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(check only one) and manner stated. 29b. Signature and title of dertifier

6 Could not be

determined

Hspiration

25. Was case referred to medical

examiner?

1 Natural

2 Accident 3 Suicide

4 - Homicide

29a, Certifier

29c. License number Res - 000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

matthew

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Mar	yland /		artment of I tificate of I				giene Reg. N2	011	24653
Physic	ian/	1. Decedent's Name (First, Mid								Date of De Month	ath Day		3. Time of Death
	lical	Leroy Col 4a. Facility Name (if not institute)		umber)			4b. City, Town, o	r Location	n of Death	July 1		Ounty of Dea	8:55 PM
LAGIII	mei	Fort Washingt		,	Rehab		Fort Wa						Georges
Funera Directo		5. Social Security Number 263–18–3763	6. Sex 1 X M 2 □ 8	7. Age (l	n yrs. last bir 96	thday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir (Month, Da 02/23/			thplace (State or Foreign ountry) corgia
nd how at		Usual Residence of Decedent 10a. State 10b. Cour	nty	1	0c. City, Tow	n or Loc	ation						10d. Inside City Limits
/anyla 8a-f s tified	Funeral Director	Virginia Fair	fax		Alexa	ndri	а						1 🗆 Yes 2 ื No
a or 2 be no	Ö	10e. Street and Number					10f. Zip Code		-		10g. Citize	en of What C	ountry?
th with ms 23 must	inera	7161 Silver L				$\overline{}$	22315				US		
Land 21215-0036 ce filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show it event, the Medical Examiner must be notified at	्रि	11. Marital Status 1 Never Married 2 N 3 W Widowed 4 Divorce	farried 1 Ye	Forces? s 2 🔀 No Sive		If	/as Decedent of F Yes, specify Cuba ☐ Yes 2 ☑ No	an, Mexica	an, Puerto F	city Yes or No- Rican, etc.)		4. Race - Ame Black, Whit pecify: B1 .	e, etc.
5-0(hours 'natur	Completed		dent's Education ghest grade complete		16a	Deced	ent's Usual Occup	ation			_	d of Business	
121 thin 72 the. than '	l E	Elementary/Seconday (0-12		(1-4 or 5+)		life. DC	ind of work done NOT use retired)	_	st of Workin	ig		. T-1.	1 D. 41 1
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Ore, Maryland 21215-0036 I and 2 should re filed within 72 hours after of Heath and Mental Hygiene. If item 27 is marked other than "natural", o rother trau atte event, the Medical Exam		19a. Informant's Name/Relatio			1		1,1				1437		p Code) 22315
		Leroy Collins 20a. Method of Disposition	, Jr.		20h Place c	of Dispos	ition (Name of	- :		, Apt.		ation - City or	candria, VA
Page 1 nent of 1 ant: If it		1 Burial 2 🔀 Cremati 4 Donation 5 D Othe		m State	Funera	ry crem	atory or other place hoices o	re)	7/20/			•	Virginia
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature g uneral Serfic			Chane	22.	Name and Addre	ss of Faci	lity Fune	eral Ch	oices	of Ch	antilly
		23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications tha	t caused th	e death. Do								Approximate
Physician		Immediate Cause (Final disease or condition	_ a	Dan	int:	a							Interval Between Onset and Death
Medica Examine		resulting in death)	Due t	o (or as a co	onsequence	of):	rotic 1	Low	LD	Scan	0		
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BOX 68 death certifi he attending ed for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o		pregnancy Fetal deat	h 3□	Ectopic pregnance	ov			23	d. Date of de	livery
J. BO the deat by the at ached fo	Physician/M	1 Yes 2 No 9 Unknown	4 □ Pre 9 □ Un		me of death	5 🗆	Other (specify)					Month	Day Year
s that the igned by be detack	<u> </u> ≥	Part II. Other significant cond	itions contributing to	death but r	not resulting	in the un	derlying cause giv	ven in Par	t I.				the cause of death?
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VIII hysic his ce	100	1 🗆 Yes 2 🕦 No	Hospital:	☐ Inpatient	2 🗆 ER/Ou	utpatient	3 DOA Othe	er: 4 2 0	Nursing Hom	ne 5 🗆 Resid	dence 6	Other (Spec	cify)
OCT OT anding P eath. rr. After t	Certificate:	27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	ding (Mo	e of injury onth, Day, Ye		Time of njury	28c. Injury work M 1 🗆	yat :? Yes 2 🏻		8d. Describe h	now injury o	occurred	
DIVISION OI all or Attending PI s after death. al Director, After the		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rminad 28e. Plac	ce of Injury ding, etc. (S	- At home, fa Specify)	rm, stree	et, factory, office		2	8f. Location (รั City or Tow		Number or Ru	ral Route Number,
LIVISION OF VITAL RECORDS, F.O. BOX 68/17 to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L Medica	ng Physician: To the I Examiner: On the b ng Nurse Practione	asis of exam	nination and/o	or investig	gation, in my opinio	on, death o	occurred at the	he time, date a	ind place, ar	nd due to the	cause(s) and manner stated.
To the within to the committee of the commitment		29b. Signature and title of certi	fer /				29c. License	number			29d_Date s	sianed (Mont	h. Dav. Year)
le		30. Name and address of person	n who completed ca	use of death	h (Item 23a) (Type, Pri	int) Livings	mi	Zon l	Fat	WASH	infin	may/at
Sta Regist	ate rar	31. Date filed (Month, Day, Year		Registrar's		e							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24654 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 8:07 a.M Jethro Clay Medical 4a Facility Name (if not institution, give street and number) , or Location of Death 4c. County of Death Examiner nes timove N/A8. Date of Birth (Month, Day, Year) 10/26/1941 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours 1 🔀 M 2 🗆 F 212-40-0119 69 Director Georgia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4409 Eldone Rd. 21229 U.S.A death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 1X Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", 3 Widowed 4 Divorced Completed Black Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 9th Grade (0-12) College (1-4 or 5+) Beth Steel Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Clay Dollie Mae Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Clay(son) 4409 Eldone Rd., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 07/18/11 Owings Mills, MD ²Joseph H. Bron Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 1 21. Signature of Funeral Service Licenses PA MD 21217 etuch 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ARDIAS akneesin Medical Due to (or as a consequence of Examiner Artersclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical (しい) Jeナトロ Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death ed by the a 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes r een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, p. ge 2 s has ! autopsy this certificare Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home } 5 \(\text{Nesidence } 6 \(\text{Other} \) Other (Specify) 2 **X**No 은 1 Inpatient 2 XER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FB 2592221 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHTON BACTIMOR 31. Date filed (Month, Day, Yea 32 Registrar's Signatu State 18 Registrar

OHMH 17 Flav 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan					/lental Hy	giene			01655	
	11 the second		State Registrar	Loot		Cer	tificate o	of Deatl	h		Reg. No.	2011		<u> 24655</u>)
	Physicia	n/	Decedent's Name (First, Middle, I	C						2. Date of De	ath Day	Year		3. Time of Death	4
	Medic		4a. Facility Name (if not institution, g	give street and number)			4h City Toy	n, or Location	on of Death	12414	37	County of De		5:17 P M	
	Examin	е	aha.	Hospital			45. City, 10V	A 20	AAA1		40.	Roll 1	am	0.00	
	Funeral			6. Sex 7. Ag	e (In yrs. Ia	ast birthday)	If Under 1		der 24 Hrs.	8. Date of Bir		9. 5	Sirthpla	ice (State or Foreign	n
	Director		220-54-6401	1 □ M 2 XX F	50	O Yrs.	Months D	ays Hour	s Min.	8/9/19	60 ^{ear)}	Ma	ary	land	
	nd how at	_	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation						100	d. Inside City Limits	_
	arylar a-f sl	Director	Maryland Baltim	iore		sterst								1 🗆 Yes 2 🛣 N	
	or 28 e not	Dir	10e. Street and Number				10f. Zip Co	de			10g. Citi:	zen of What (Countr	y?	_
	with s 23a ust b	Funeral	47 Glyndon Trace	Drive			21136	5			U.S.	Α.			
	death items	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	er in U.S	6. 13. V	Was Decedent	of Hispanic	Origin? (Spe	ecify Yes or No- Rican, etc.)	1	14. Race - An			
36	after (I", or kamir	l by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2XX If Yes, Give	No		Yes 2			riiodii, oto.,		Black, Wh Specify: Wh		S.	
8	atura cal E	etec	15. Decedent's	Year or Dates.			dent's Usual O				_				
715	n 72 h i. an "n Medi	Completed	(Specify only highest Elementary/Seconday (0-12)	t grade completed))	(Give I	kind of work di O NOT use ret	one during m	ost of work	ing		nd of Busines		-	
2	within giene ler th		Elementary/Seconday (0-12)	College (1-4 or 5	0+)		cial Ad		ant		Hea ⁻	ith In:	sur	ance	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Las	st)						e (First, Middle,	Maiden S	Surname)			
Sa	uld be Men narke natic	1	William Suelau					AIM	a San	try					_
Mai	12 should be file alth and Mental I 27 Is marked o r traumatic eve		19a. Informant's Name/Relationship Christopher Cul		and		ng Address (St yndon			al Route Numbe				_{de)} and 21136	;
هٔ آ	and Heal tem 2		20a. Method of Disposition	Otta / Husb	_		sition (Name o		T	Date		cation - City			_
ē	Page 1 nent of ant: If it ury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	3 Removal from State	C	emetery, cren	natory or other ervice	place)	1			son, M			
를	permit. Page Department of Important: If any injury or once,		21. Signature of Function Service Lie		7	1 LOP 3	. Name and A	ddress of Fa	i o/ ɔ/ ː	k Towso					
m	permi Depar Impo any ir		XIVIA	10/11/1	in	- 1	050 Yo	rk Roa	d To	wson, M	aryla	and 21	204	c, 11101	d
			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caused	the death	n. Do not ente	er the mode of	dying, such	as cardiac o	or respiratory ar	rest,			Approximate nterval Between	
- ~	Physician/		Immediate Cause (Final disease or condition	Kla	- 00	. F.	10. 1	10.00	'n.					Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):	Heraking	eyor.	ing				 '	1000	
	ZAGITIITO	er	Sequentially list conditions,	b	nti	unlaw	- fib	rolle	wy				-	days	_
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	ience of):									
	xecut n and al-trar		that initiated events resulting in death) Last	c. Due to (or as a	a consequ	lence of):							+		_
09	ite be executed hysician and he burial-transit	dical		d											
876	ifficate ng phy as the	Med	IF FEMALE:												_
Box 687	requires that the death certificat been signed by the attending ph should be detached for use as ft	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Ectopic preg	nancy			2	23d. Date of c			
Bo	e deat the at ned fo	/sic	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	leath 5	Other (specin	y)				Month	D	ay Year	
<u>Р</u>	at the		Part II. Other significant conditions	s contributing to death b	ut not resi	ulting in the u	nderlying caus	se given in Pa	art I.	23e. Did t	obacco us	se contribute	to the	cause of death?	_
S,	ires the signed of be of	d by								1 🗆				bly 4 🗌 Unknow	n
ord	/ requ	lete								24a. Was	an	24b. Were a	autops	y findings available	_
ec	he law te has age 2 s	Completed								auto perfo	psy ormed?	prior to death?	o com	oletion of cause of	
<u>a</u>	sician: The la certificate ha irector, page 2	BeC	25. Was case referred to medical				2	6. Place of D	Death (Check	1 L Yes	2 No	1 🗆 Y	es 2	1200	_
Ĭ	nysici nis ce I direc	70 E	examiner? 1 Yes 2 No	Hospital:	ent 2 🗌	ER/Outpatien	nt 3 🗆 DOA	Other: 4	Nursing Ho	me 5 Resi	dence 6	Other (Spe	ecify)		
Division of Vital Records,	*Attending Physician: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transition.		27. Manner of Death 1. Natural 5 Pending	28a. Date of inju (Month, Day	ry <i>, Year</i>)	28b. Time of injury		Injury at work?		28d. Describe I	now injury	occurred			
loi	ttendi death tor: A the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	ation				1 Yes 2							_
N	or Al after or Direct in by	Cer	4 Homicide determine				eet, factory, of	ice		28f. Location (S City or Tov	Street an <i>d</i> vn, State)	Number or F	lural R	oute Number,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun		29a. Certifier	Physician: To the best of	my knowle	edge, death o	occured at the	time, date ar	nd place, an	d due to the ca	use(s) and	manner as s	tated		_
	ne Ho n 24 h ne Fui pletec	Medical	(Check 2 Medical Exa	aminer: On the basis of ex Nurse Practioner: To the	xamination	and/or invest	igation, in my o	pinion, death	occurred at	the time, date a	and place,	and due to the	e caus		ed.
	To the vithin com,	-	29b. Signature and title of certifier	- /				ense numbe				e signed (Mor			
			1	X			Da	2561/2	2)		Uh.	1 30}	4	2011	
Ū			30. Name and address of person wh	ho completed cause of de	eath (Item	23a) (Type, P	rint)	,					,		
	Char		31. Date filed (Month, Day, Year)	A MAS ST	W1 Signat	9106	ourst	1d	Roy	adal SA	, pho	dro.	111	33	_
	Stat Registra		AUG 032	2011 Aregistra	· a signal	1. Apa	are a				-				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygien of Registrar

State of Maryland / Department of Health and Mental Hygien of Occilificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 12:15 PM Physician/ Dotter Jr. Edwin Henry Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timose Franklin 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Months Days Hours (Month, Day, February Mary land 218-22-9809 82 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Baltimore Dundalk 1 ☐ Yes 2 💢 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21222 8217 Bullneck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedon... Armed Forces? ¹ ☐ Yes 2 🔀 No 1 Never Married 2 Married ð 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Steel 11 years Supervisor - Foreman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Hazel Pugh Edwin Henry Dotter Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Dotter wife 8217 Bullneck Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 15, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer Methodist Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Church Cemetery Comments Fufferal Home Of 7110 Sollers Point Road, re of Funeral Service Licens Dundalk, P.A. Dundalk, Md. 21222 23a. Part 1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final psi disease or condition resulting in death) Due to (or as a consequence of): Examine

Pnysician/ Medical **Examiner**

or 28a-f shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I feem 27 is anaked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Dotter

Physician/Medical 3 Be Completed

힏

Certificate:

Medical

29a. Certifier

only one) 29b. Signature and title of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Registrar's Signatu

Shinn Day, Year)

JUL 2 9 2011

and burial-trar attending physician detached for signed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific funeral director,

The law requires that the death certificate be

Division of Vital Records, P.O. Box 68760

f any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	CERTIFICATION APPROVE	BYMEDICAL EXAMINER	
FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3. If yes, outcome of pregnancy 1			ate of delivery onth Day Year
art II. Other significant conditions con	tributing to death but not resulting in the underlying caus	e given in Part I. 2	3e. Did tobacco use con	tribute to the cause of death?
Myltiple M	yeloma.		1 🗆 Yes 2 🔀 No	3 Probably 4 Dunknown
acute Kidney	,	2	24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
Coronary Art	ery Disease	1	Yes 2 No	1 Yes 2 No
5. Was case referred to medical	20	6. Place of Death (Check only of	one)	
examiner? 1 X Yes 2 X No.	ospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5	☐ Residence 6 ☐ Oth	ner (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	njury at 28d. D work? 1 🗆 Yes 2 🗆 No	escribe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	ice 28f. Le	ocation (Street and Numb ity or Town, State)	ber or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0053694

Square Drive Baltimore MD

29d. Date signed (Month, Day, Year)

29c. License number

Registrar

State

completed filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland /	Department of Health and No. Certificate of Death	/lental Hygier Reg. t	2011	24657
	Physicia Medic	_	1. Decedent's Name (First, Middle, Last		glass	2. Date of Death Month 3	0, 20°11	3. Time of Death 3:54A M
	Examin	_	4a Facility Name (if not institution, gives	treet and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se		thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month Day 9a	43 9. Birthp Count	lace (State or Foreign ry)
	yland if show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		n or Location		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Mar or 28a- e notifi	Dire	10e. Street and Number	<u> al</u>	10f. Zip Code	10g.	Citizen of What Coun	
	th with ms 23a must b	Funeral Director	2824 Booker	12, Was Decedent Ever in U.S.	21225 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	an Indian
9000	perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Derartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 M Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, e	ick
21215-0036	vithin 72 ho jiene. e r than "nat the Medic a	Completed	15. Decedent's Ec (Specify only highest gra	ucation de completed) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give Kind of work done during most of work life. GO NOT use etired)	ing 16b	Rind of Business Inc	
	be filed vental Hygrked other	To Be	17. Father's Name (First, Middle, Last)	Souglass	18. Mother's Nan	e (First, Middle, Ma id	Dillion	J
Maryland	12 should lith and M 27 is mar r traumat		191. Informant's Name/Relationship (Ty. Ann Douglas)	oe, Print) Jis	b. Mailing Address (Street and Number or Run 824 Bookert Dr.	Balto.	or Town, State, Zip C	225
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State 20b. Place cemet	of Disposition (Name of ery, crematory or other place)	·	Location - City or To	wn, State
Baltir	permit. Po Departme Importar any injur		21. Signature of Fundfal Service Licens	1000	22 Name and Addres Of Facility (2)	re Fuser		
			shock, or heart failure. List only or	lications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ر. در	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Heure				
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	caren	1 /	0	
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence	in Chatration &	nlacar	1 Misease	•
09	icate be executed graphsician and sr the burial-transit	edical	C	d				
Box 68760	To the Hospital or Attending Physician; The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delive	ery Day Year
s, P.O.	ires that the signed by t d be detach	by		entributing to death but not resulting	g in the underlying cause given in Part I.	II.	co use contribute to the	ne cause of death?
Division of Vital Records, P.O.	The law requate has been page 2 shoul	Completed	High Bloom	1 Pressure		24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available mpletion of cause of
/ital	sician; certifica irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※No	Hospital: 1 ☐ Inpatient 2 🗗 ER/0	26. Place of Death (Chec		e 6 🗆 Other (Specify	()
ر Jo ر	ding Phy n. After this funeral d	ate: To	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	Time of injury M 28c. Injury at work? M 1 Yes 2 No	28d. Describe how in		/
ivisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 %	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,
	Hospital 24 hours Funeral I	Medical	(Check 2 Medical Exami	ner: On the basis of examination and	e, death occured at the time, date and place, a Vor investigation, in my opinion, death occurred	at the time, date and pl	ace, and due to the ca	use(s) and manner stated.
	To the within 2 To the comple	ž		L. B./ 10	wledge, death occurred at the time, date and plant 29c, License number	29d.	Date signed (Month,	Day, Year)
0 v	/		30. Name and address of person who c		O(Type, Print) Hawover Str			
UV	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registr	ar	AUG 0 3 20	11 1	had.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24658 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 JULY Month Physician/ RUDDY DIVELY 28, 6:17A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4310 FLINT HILL DR. # 103 OWINGS MILLS BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 □ F Hours (Month, Day, Year) Months Yrs **Director** 175-52-6582 1940 Feb_6. Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho cdical Examiner must be notified at Director 1 ☐ Yes 2√√ No Baltimore Owings Mills 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4310 Flint Hill Rd. 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 x Never Married 2 Married Yes XX No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Dively Grace Dively 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Chalfonte Dr., Catonsville, MD 21228 Darlene Schoenfelder Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3XX Removal from State cemetery, crematory or other place, Alto-Reste Park Aug 1, 2011 Altoona, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Li 22 Name and Address of Eachity FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT K. CRECORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, shock, or heart feilure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph. sician/ andiopul mon cuy disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Month Day Yes 2 No Part II. **Other significant condițions** contribuțing to death but not resulting in the underlying cause given in Part I. signed l d be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home ** Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Wath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work?
1 Yes 24 hours after death.

Funeral Director: A 2 \square No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

Dively, Budd

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHEILA WALKER, M.D. 711 W. 40th ST. BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24659 Reg. 12 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aug. 02^{pay} 2011 11:30A M Levi Davis, Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA 301 McMechen Street Apt.#311 Baltimore 5. Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Min Hours Director 217-40-3383 28a-f show 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 McMechen Srteet Apt. 311 21217 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1X Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifAfrican-American Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Millennium Chemicals Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Joseph Davis, Sr. Deborah Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella M. Davis/Wife 301 McMechen Street Apt.311 Baltimore, Maryland 21217 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/9/2011 Garrison Forest Owings Mills, Maryland f Funer 22. Name and Address of Facility Wile Funeral Home P.A. Of Balto. Co. 19200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final MAGCODDIAC Onset and Death Ph sician/ IN FARCTION disease or condition Medical resulting in death) equence of) **Examiner** HS 6M2 T 43,00 SC212071C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \(\subseteq \text{Yes} 5 Pending s after death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifie 29d. Date signed (Month, Day, Year) 0-13619 8.2-11

Registrar

DHMH 17 Rev 7/2009

State

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HUNZ

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LCHAW

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan					001	1 21 6	c 0
			State Registrar	Cei	rtificate of Deatl			eg. NZ U	1 2466	טכ
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	Day Y	3. Time of D	
	Medic Examin		Colleen Ann Dark 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		uly 30	2011 4c. County of	8:40pr	<u>m ""</u>
	LAdillii	CI	Gilchrist Hospice		Towson				timore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)		der 24 Hrs. 8.	Date of Birth (Month, Day,		Birthplace (State or F Country)	Foreign
	Director		216-52-8051 1 1 M 2 XI F 61 Usual Residence of Decedent	Yrs.	Working Days Hour		ept. 14	4.1949	MD_	
	and show	or		y, Town or Lo	cation				10d. Inside City	Limits
	Maryla 28a-f	Director	MD Baltimore Re	eister	stown				1 🗌 Yes 2	2 X No
	a or 2	iO le	10e. Street and Number		10f. Zip Code	·	1	0g. Citizen of Wh	at Country?	
	th with ms 23 must	Funeral	315 Cherry Chapel Road		21136	_		USA		
	r deal	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	3. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify ican, Puerto Rica	Yes or No- an, etc.)		American Indian, White, etc.	
99	s afte ral", o Exan	q pe	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🎇 No Spec	cify:		Specify:	White	
2-0	2 hour "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during n	nost of working		16b. Kind of Busi		
121	thin 7%	om	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)			CBS Radi	io	
р Б	ed wit Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last)	Natio	onal Sales As	other's Name (Fi			-0	
an	be fill lental rked c	10	John W. McCarty			Marjorie		,		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Nur				e, Zip Code)	==7
Σ	ealth a m 27 in rer tra		Johnny Dark Husband	315 (Cherry Chapel	l Road,	Reiste	rstown,	MD 21136	
Baltimore,	ge 1 a t of H If itel or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	lace of Dispo emetery, crei	osition (Name of matory or other place)	Date	•	20c. Location - C	ity or Town, State	
<u>Ħ</u>	it. Pag rtmen rtant: njury			_	n Memorial	8/3/2		Finksbu		
Ba	permi Depar Impo any ir	ļ	21. Signature of Funeral Service Licensee		2. Name and Address of Fa Eline Funeral	-			rstown Road	1
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.						MD 21136 Approximate	
4	Ph_sician/		Immediate Cause (Final	e+ (Concer				Interval Betwee	een ath
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of the condition o	uence of):	ci) rice e re				1	
	Examiner	<u>.</u>	Sequentially list conditions, b.							
	p #i	Examiner	if any, leading to immediate Due to (or as a consequence. Enter underlying	uence of):						
R	ecute and Il-tran	Exar	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of the consequence).	uence of):						
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376	ificate ig phy as the	Med	IF FEMALE:							
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B	deat the at ned fo	Physician/Me	1 Yes 2 No 4 Pregnant at time of c	death 5	Other (specify)			Monti	n Day Yea	ar
P.O.	requires that the death certificat been signed by the attending ph should be detached for use as the		Part II. Other significant conditions contributing to death but not res	ulting in the i	underlying cause given in P	Part I.	23e. Did tob	acco use contribu	ute to the cause of dea	ath?
S,	ires the sign of t	d by					1 🗆 Ye	es 2 No 3	☐ Probably 4 ☐ Ur	nknown
ord	w requ	olete					24a. Was ar		re autopsy findings ava	
Records,	The lar	Completed					autops perform	med2 dea	or to completion of cau ath? ☐ Yes 2 ☐ No	use of
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Division of Vital	Physic this c	ပ္	1 Wes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatie				nce 6 Fother	Specify)	ne
0 0	ding th. After funer	Certificate:	1 Natural 5 Pending (Month, Day, Year)	injury	f 28c. Injury at work? M 1 \sum Yes 2		. Describe ho	w injury occurred		
Sio	Atten	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At ho						or Rural Route Number	r,
2	tal or rs afte al Dire ed in l		building, etc. (Specify)			City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ploompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check (ner stated.
	thin 2 the formplei	Me	only one) 3 Certifying Nurse Practioner: To the best of m			dat e and place, ar	nd due to the		ner as stated.	
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	0		30. Name and address of person who completed cause of death them	23a) (Type, f	Print) Daso	~	1 0.			
	10		W.A. Riley Bine 6	701	N-Charles	st. B	alto	md.	2(20)	
	Stat		31. Date filed (Month, Day, Year) AUG 0 3 2011 Aug. 32. Registrar's Signa	ture						
	Registra	r	mode of coll comments.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #* Per FH C918 8/05/2011 Th
State of Maryland / Department of Health and Mental Hygiene | | |

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			Registrar 1. Decedent's Name (First, Middle,	. Last)		Ce	lillCate	010	eaur		2. Date of De	Reg. No.		1	3. Time of [Death
	Physicia		Mildred Dricil		nev					- 1	Month 07	30 ^{Day}	20 ^{Ye}	ar	7:45	
	Medic Examin		4a. Facility Name (if not institution,				4b. City,	Town, or	Location o	f Death			County of E			
			7719 Buckhill	Road			Ki.	ngsv:	ille				Baltim	ore		
	Funeral			6. Sex 1 \(\sum M 2 \) X	_	yrs. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8.044 or Sir	/1910 y, Year)_	9.	Birthplac Country) Mary	e (State or	Foreign
	Director		219-01-6446 Usual Residence of Decedent	T		95 Yrs.					04/15/	1915	[Mary.	Land	
	ind show at	5	10a. State 10b. County		10	c. City, Town or L	ocation							10d.	. Inside City	y Limits
	Aaryla Ba-f s tified	Director	MD Balt:	imore		Kingsvi	lle								1 🗌 Yes	2 X No
	the h	ē	10e. Street and Number	LINOLO		1(1119D V 1	10f. Zip	Code		_		10g. Cit	izen of Wha	t Country	?	
	s 23a	Funeral	7719 Buckhill	Road			21	087				U.	S.A.			
	death 'item ner n		11. Marital Status	12. Was I Arme	Decedent Ever d Forces? Yes 2 X No	in U.S. 13.	Was Deced If Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - A Black, V	American Vhite, etc.		
22	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marr 3 🛱 Widowed 4 ☐ Divorced	If Yes	Yes 2 X No , Give or Dates.		1 🗆 Yes	2 🕅 No	Specify:				Specify: W	hite		
ž	hours natura ical E	lete	15. Deceder	nt's Education		16a. Dece	dent's Usua	Occupa	ation				ind of Busin	_		-
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7	with ygien her th t, the		12			Pay	roll .	Acco					S. Arm	ıy		
	be filed within 72 hours after death with the Maryland and Hygiene. Red oith Hygiene. Red of the Wastural", or items 23a or 28a-f sho ked oith than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L					1			(First, Middle,	Maiden	Surname)			
Š	and 2 should be file Health and Mental H Idem 27 is marked o other traumatic eve		William Knight 19a. Informant's Name/Relationsh			405 14-5		/C4===4 =			umpf Route Number	r City or	Town State	Zip Coc	(a)	
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9	Page ent o		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		from State	cemetery, cre				ns/ n	4/2011	Rel	Δir	Mary	land	
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications to only one cause of	n each line.								4	In	pproximate iterval Betw inset and D	veen
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	ringri	SCLER	DTIC	CI	ROLL	VAS	WIAR	DE	STAGE		HR1	
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	execian an	Ē	resulting in death) Last	Du	e to (or as a co	onsequence of):										
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000	entifica ding p	Physician/Me	IF FEMALE:	23c. If ves	, outcome of p	oregnancy							22d Data a	f delivery		
XOD	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 🔲		Fetal death 3	☐ Ectopic ☐ Other (s.c.		у				23d. Date o Month	Da Da		ear
Ď	y the	hysi	9 Unknown		Unknown											
л Э	that the	by P	Part II. Other significant condition	ons contributing	to death but	not resulting in the	underlying	cause giv	en in Part	I.	23e. Did	obacco (use contribu	te to the	cause of de	eath?
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E E	cian; ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:				26. Pla	ace of Dea	th (Check	only one)					
>	Physical this call dire	2	1 Yes 2 No		1 Inpatient Date of injury	2 ER/Outpati		8c. Injury	4 ∐ Nı		me 5 Resi 28d. Describe			Specify)		
n 01	ding h. After funer	ate	1 Natural 5 Pendir 2 Accident Investi	ng (Month, Day, Y		M Z	work		- 1	zod. Describe	now injur	y occurred			
<u>s</u>	Atten r deal ctor:	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. F		- At home, farm, s		, office			28f. Location			r Rural Ro	oute Numb	er,
DIVISION	al or safte		4 C Homicide determ	illied	ouilding, etc. (8	Specify)					City or To	wn, State)			
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check 2 Medical B	Physician: To	the best of my	knowledge, death	occured at	the time,	, date and	place, an	d due to the c	ause(s) ai	nd manner a	s stated.	e(s) and mai	nner stated.
	the H hin 24 the F	Me	only one) 3 Certifying	Nurse Practio	ner: To the bes	st of my knowledge	, death occu	red at the	e time, date	e and plac	e, and due to t	ne cause(s) and mann	er as state	ed.	
	5 2 wit		29b. Signature and title of certified	1 Val	are	71	290	License	number	167	00	29d. Da	te signed (N	ronth, Da	y, rear)	,
			30. Name and address of person	uba assertati	cours of day	h (Itam 22a) (Time	Print)	V	041	05	54	AL	4. VS1	11	201	7
) »	/		Name and address of person	who completed	MA	h (Item 23a) (Type	M.D	17	7/2 /	YAR.	Form.	Rl:	R. 10.	FA	WERK	1 410
	Sta	te	31. Date filed (Month, Day, Year)		32 Registrar's	Signature		7	- 0_//	, , , , , ,	-,		7-0			
	Registr		AUG 0.3	2011	Viewa	. B. A	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\mathbf{July}^{\mathsf{Month}}$ Physician/ 28 2011 10:57P M Lisa A. Davis Medical 4c, County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Community Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 1 □ M 2 🗓 F Months Davs Hours Min 56 Director pr 15. 159-46-5531 1955 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland Director must be notified Washington 1 Tes 2 No DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 items 23a Funeral 20019 5435 C Street, SE, Apt#3 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Government Morgue Technician 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William W. Wilson Dorothy Blake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Last 19a. Informant's Name/Relationship (Type, Print) 950 Ontario Street, Philadephia, PA 19134 Lisa Davis/ Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Riverdale, Maryland Riverdale Crematory |8/2/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HAPOKICA -₹nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** preumonia atera Sequentially list conditions Examine if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit positive COCCI 9 ram Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Dlabeter mellitus 24a. Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title

and address of person

31. Date filed (Month, Day, Year)

W

AUG 03

G HOTPHAP

who completed cause of death (Item 23a) (Type, Print)
Boy Ce PG Horustal

2. Registrar's Signature

29c. License number

D0043662

29d. Date signed (Month, Day, Year)

3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

28 ,2011

11-05253 Angela Davis-Gaines Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 24663

		1- For State Registrar		Certif	icate of	Death			Re	g. No.		
Physici		Decedent's Name (First, Middle	e,Last)						Date of Death Month	n Day	Year	3. Time of Death
fedical Exam	iner	Angela Davis	-Gaines					J	uly 14, 20	11		2021 hrs
		4a. Facility Name (if not institution	-)	4	b. City, Town, o	or Location of	f Death		4c. Co	ounty of Death	1
		Mercy Medical Center				Baltimore						
Funeral		5. Social Security Numberunk	6. Sex 7. Ag	je (In yrs. last	birthday)	If Under 1 Ye					Facel	thplace (State or UNK gn
Director			1 M 2 F	26	Yrs.	Months Da	ys Hours	Min. J	une 24	, 19		untry)
		Usual Residence of Decedent					7					
any		10a. State 10b. County	unk	10c. City, To	wn or Locati	on unk						10d, Inside City Limits
i	_	MD										1 Yes 2 No
Aaryland 28a-f show 1 at once.	cto	10e. Street and Number unk	3	<u> </u>		10f. Zip Code	unk		10	g. Citizen	of What Cou	ntry?
ith the Maryland 23a nr 28a-f sho notified at once	Director									USA	L	
rith th 1 23a 1 23a	ral	11. Marital Status UNK	12. Was Deceden	Ever in U.S.	13. Was	Decedent of H	lispanic Origi	in? (Specif	fy Yes or No-	14.	Race - Amer	ican Indian, Black,
ath v items	nue	1 Never Married 2 Ma	arried Armed Forces	_? unk	If Ye	es, specify Cuba	an, Mexican,	Puerto Ric	an, etc.)		White, etc.	
er de	ш	3 Widowed 4 Div	orced If Yes, Give Year	∐ No	1	Yes 2 N	o specify:			Spe	ecify: bla	ick
urs afi ural	by	15. Decedent's Education (Spec	or Dates:	npleted) 16	Sa. Decedent	's Usual Occup	ation (Give k	ind of work	doneunk	16b. Kind	of Business/	IndustryUNK
5-0036 led within 72 hours a flygiene. other than "naturs the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or	_	during mo	ost of working lif	fe. DO NOT u	use retired)				
36 thin 72 than than edical	ם	unk	unk									
d with	ő	17. Father's Name (First, Middle,	Last) unk			·	18.Mother's	s Name (Fi	rst, Middle, M	laiden Sur	name) uni	
e file al Hi	Be (
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene, "I marked other than "matural", or items 23a nr 28a-fahn natic event, the Medical Examiner, must be notified at once	2	19a. Informant's Name/Relations	hip (Type, Print)			Address (Stre						
MD d 2 should hand and and and and and and and and and		Mercy Medica	al Center	Ī	301	St. Pa	ul P1;	; Bal	timore	, Mai	yland	21202
and 2 and 2 fealth a traum		20a. Method of Disposition				tion (Name of c	emetery,	D	ate	20c. Loc	ation - City or	Town, State
ges 1 t of 1 t of 1		1 Burial 2 Cremation	_	ale	matory or oth	ier place)						
tim trent trent		4 Donation 5 Dother Sp	oecify: in state	2	22 N	ame and Addre	ss of Facility	Stat	a Anai	Omy	Board	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury an nather traumatic event, the Med		21. Si mab of Funeral Stryice Onald	Day Dar	ector		55 W. B						21201
		23a. Part Enter the disease, or	complications that cause	the death. Do								Approximate Interval
Physician Medicul		failure. List only one cause	on each line.									Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a cons									-
		or corporation recording in a cash,	bue to (or as a cons	equerice or).								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	с									
T #5	xar	events resulting in death) Last	Due to (or as a cons	equence of):								
760, cate be executed physician and the burial - transit			¬ d									
60, cate be execut physician and he burial - tra	Medical	UNPENDED	AMENDED									
760, cate be er physiciar the burial		IF FEMALE:	23c. If yes, outcome	me of pregnar			Ectopic				ate of deliver	- 11
Box 687 e death certifi the attending ed for use as t	ian	past 12 months?	I	t time of death			Ectopic	pregnancy	′	MIC	onth	Day Year
OX eath c for us	sic	1 Yes 2 No 9 ✔ Unk			5 Oth	ner (Specify)				20		
D. B. trthe de by the	Physician	Part II. Other significant condit		th but not resu	Ilting in the u	nderlying cause	given in Par	rt I.	23e. Did to	bacco use	contribute to	the cause of death?
res that the signed by	by	25 m							1 Yes	2 🗸 N	o 3 Pro	bably 4 Unknown
on of Vital Records, P.O. Box 687 ending Physician: The law requires that the death certificath. The After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as the	Completed								24a. Was a	ın l	24b. Were a	utopsy findings available
cords, law requir has been s	ple								autop: perfor	sy	prior to death?	completion of cause of
Rec The la	Eo								1 Yes	2 No	1 🗸 Y	es 2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medica				26.Pla	ce of Death (Check only	/ one)			
Vita hysicia this ce	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗹 El	R/Outpatient	3 DOA	Other ₄	Nursing H	lome 5	Residence	6 Othe	r:
Division of Vital Records, tal or Attending Physician: The law require as after death. Director: After this certificate has been sided in by the fineral director, page 2 should b	-	27. Manner of Death	28a. Date of In	ury 28	8b. Time of I	njury 28c. In	jury at Work		d. Describe h			
on ath. or: A	<u>ā</u>	1 Natural 5 Pend			OUND: 923 hrs	1	Yes 2	No Su	ibject peu	coman.	Struck	
r Att	<u>E</u>					et, factory, office	building, etc					ural Route Number, City
irs aft	Certification:	Suicide	ermined (Specify) Lo	cal Street				400	0 blk of the	Fallsway	, Baltimore	, MD
Huspital 24 hours Funeral etely filled		29a. Certifier 1 Certifying P	thysician: To the best of r	ny knowledge,	death occur	red at the time,	date and pla	ce, and du	e to the caus	e(s) and m	nanner as sta	ted.
Division To the Hnspital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 ✓ Medical Exa	miner:On the basis of example and manner stated	amination and	or investigat	ion, in my opini	on, death occ	curred at th	e time, date	and place,	and due to the	ne cause(s)
S wir S	Me	29b. Signature and title of certific				29c, Lice	nse number			29d. Dat	e signed (Mo	onth, Day, Year)
		h 11.	3 0/17	M		0.0	C.M.E.			July 1	5, 2011	
		30. Name and address of person	who completed cause of	death (Item 23		_					_	
		Melissa Brassell, MD	Assistant Medica			. Baltimore	Street, Ba	altimore,	MD 2122	3		
	tate			ar's Signature			<u> </u>					
Regis		AUC O S		A	par	Kar						
			- I LI I Amelia I									

DHMH 17 Rev 1/2001 OCME 2006

OGME

ORIGINAL -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G918 8/03/2011 JH
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 315 Baby Boy Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Wester Baltimore Medical Baltimore BAITIMBIL 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Mary and Min. Month Day Hours **Director** INFANT Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Catonsville Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 425 Overbrook Rd items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes 2 No 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) nfan Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hvo 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) မ Mam manda 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) "town He OVERBOOK Tmandh 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Nother (Specify) in state Sign turn of Suneral Service Licer St. Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1 shock, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prematurit disease or condition resulting in death) xtreme Medical Due to (or as a consequence of) Examiner amniotic Membranes Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed norisamnioni TIS that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) Suite 14 Lutherville OIKK led (Month, Day,

DHMH 17 Rev 7/2009

State Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G918, 8/3/2011 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 24665 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTH DIAMOND JULY 2011 04:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WEINBERG PARK ASSISTED LIVING BALTIMORE N/A Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours 0371571925 86 Yrs. 217-20-9183 Director NC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No WARRENTON NC WARREN 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? must be Funeral 23a 311 HARRIS STREET USA 27589 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify Specify: Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER RETAIL STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAX PERMAN SADIE LAVINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN STREIMER/DAUGHTER 4600 MEWS DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🖾 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH MOSES CEMETERY 08/02/2011 PINELAWN, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Leuns Mall 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final OBSTRUCTIVE Onset and Death PULMUNARY Ph_sician/ DISEASE Chronic 40cm disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence on attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending adversarial. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> , pertension Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No DIMBIETES MELLITUS 24a, Was an page 2 autopsy performed completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted

Other (Specify)Living examiner? Hospital Other: 4 Nursing Home 5 Ans 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Matural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 03037

Registrar
DHMH 17 Rev 7/2009

State

120BERT

31. Date filed (Month, Day, Year)

AUG 03

PARK

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BALT

AVE

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21215

6503

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

M. COOPER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Items 23aPtI,II,25 per 18 9 218 0 2011dhb 24666 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 1719 Ea PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 21634646 1 🗶 M 2 🗆 F Days Hours Min. Months 72 Maryland **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Pennsylvania Ave. 21201 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc ģ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", Completed 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) disabeld N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မှ Samuel Eads Alice Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Eads(son) 3300 Auchentoroly Apt. 1, Baltimore, MD21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Mt. Zion Cem. 06/25/11 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) joseph^{Adhess of}Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 1 Signature of Fureral Service Licensee PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Complications of Cholecystitis** Approximate Interval Between Complications of Cholecystitis Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE APPROVED 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertensive Atherosclerotic Cardiovascular Disease cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 XYes Certificate: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year 061 D16787

Registrar
DHMH 17 Rev 7/2009

State

110

S. Paca St Baltimore.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32/ Registrar's Signature

Si

AUG 0 2

		Pleas	e Type or Pri					-		-	
	-	For State	State of M	arylan		artment of F tificate of D		d Mental Hy	giene		
Physicia		1. Decedent's Name (First, Middle, L	ast)		001	imeate of E	704111	2. Date of De	ath Da	20 Year	32 mg ob ob of 7
Medic Examin		4a. Facility Name (if not institution, go		incle		4b. City, Town, or	Location of Do	eath		County of Dea	
Funeral Director		577-20-9193	Sex 1 ☐ M 2 🔀 F	e (In yrs. Ia 98	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 h Hours M	Irs. 8. Date of Bir Iin. (Month, Da Jan • 2	th Y1 Year) C	9. Bi Pen	rthplace (State or Foreign Duntry) INSYLVania
ıryland a-f show Ted at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washin	aton		, Town or Loc erstow						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
rith the Ma 23a or 28k st be notif	Funeral Director	10e. Street and Number 13025 Little H			CISCOW	10f. Zip Code 21742				izen of What C	1
s after c ral", or Examin	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent E	ver in U.S	H	Vas Decedent of Hi FYes, specify Cuba ☐ Yes 2 🔯 No	n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		14. Race - Am Black, Whi Specify:	
72 hour In "natu Medical	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	Education	i+)	(Give F	lent's Usual Occup kind of work done of NOT use retired)	ation during most of	working	Dep.		of Health, & Welfare
should be filed within and Mental Hygiene. is marked other tha aumatic event, the I	To Be	17. Father's Name (First, Middle, Las Chester Robins	son				Grace	Name (First, Middle, e Mae Bar	ger		
and 2 should Health and M tem 27 is mar ther traumat		19a. Informant's Name/Relationship Dennis Ellis	(Type, Print)		13025	Little			ager	stown, M	laryland21742
permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		C	_{emetery, cren} lent Cr	sition (Name of natory or other place cemation,	Inc. 7	Date -27-11	Han	over, Ma	ryland
permit. Departr Imports any inji		21. Signature of Funeral Service Lice	ronallo-		60	009Harfor	d Road	Marzullo ,Baltimor	e,Ma		- '
Physician/) Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. Deme	ntia		er the mode of dying	g, such as card	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as Due to (or a)	e Re	nal 1	ailure					weeks.
executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Herpe	s Zo	ster						weeks
wath certificate be executed attending physician and for use as the burial-transit	l edical		d. Anen	nè							years
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у			23d. Date of d Month	elivery Day Year
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the Hosp thin 24 ho the Fune mpleted f	Medical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or invest	igation, in my opinio	on, death occur e time, date and	red at the time, date	and place ne cause(s	, and due to the s) and manner a	e cause(s) and manner stated. s stated.
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/		30. Name and address of person which of the of the 31. Date filed (Month, Day, Year)	o completed cause of down or cause of down or completed cause of down or cause of down or completed cause of down or cause of down or cause of down or cause	n C	ovat	7 747	No-the	A-Spence	ita.	gersho	un 21742
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 0425 Ernestine H. Epton 24 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Memorial Hospita aston Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) UNK 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min. March 6, 1949 214-54-6693 62 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Talbot Cordova 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 21625 10496 Chapel Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 12. Was Decedent Ever in U.Sunk 14. Race - American Indian. Armed Forces Black, White, etc ρ 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UN (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Katherine Major - niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Funeral Service I ensee Ronald Wa 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No Yes After this certifications and funeral director, I 25. Was case referred to medical examiner?

1 Yes 2 No Be B 26. Place of Death (Check only one) Hospital: ၉ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No Natural injury 5 Pending n 24 hours after death. e Funeral Director: A leted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one 29d. Date signed (Month, Day, Year) 240 8 3000

State Registrar

Ernestine

WASHINGTON ST. EASTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAN

KAVITA

2195

32. Registrar's Signature

24

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24669 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 1220 PM 200 OBERT FRAYSIER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1FT1920H SPRING ROSS SILVER ONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Country) M 1 **V** M 2 □ F Months Hours Min (Month, D 216-40-9638 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No SILVER MONTGOMERY SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0906 SVA 807 LITTLETON hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced WHITE injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ERV NUN and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e ROBERT EUGENE LUCILLE PARKER FRAYSIER MARCHRET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, SILVER SPRING MD 2096 HOLY CROSS HOSPITA 1500 FOREST CALEN RS 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) ature Fineral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death SEPTIC Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). The law requires that the death certificate be executed ADVANCED burial-transi Cause (Disease or iinjury MON HODGKINS LYMPHOMA that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ၉ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 5 \square Pending Natural work 2 🗌 No 1 🗌 Yes Accident Investigation the 24 hours after dea:
Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death within 2 ccurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Monti

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32 Registrar's Signat

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SPRING MD 209K

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State me Nggyhanor//29/2011 Edhaf Death and Mental Hygiene Certificate of Death Reg. No. 20 | 24670 1. Decedent's Name (First, Middle, Last)
David C. Fultz 3. Time of Death 2. Date of Death Physician/ June 2 8°11 125 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3618 Dahlia Lane Middle River 6. Sex 1 M 2 F Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 215-46-9792 Days Months Sept. 6, 1947 MD 63 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 3618 Dahlia Lane 21220 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic pures. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD Termite Co. Exterminator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest D. Fultz Jr. Louise Stwart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23386 Potts Mill Road Middleburg VA. Forrest G. Fultz /brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cremation 3 Removal from State cemetery, crematory or other place) 1 Burat Bayview Crematory 6/22/11 Baltimore MD n 5 Other (Specify) Donatio 22. Name and Address of Facility 21. Sign eral Se vice Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury ue to for as a consequence off EXAMINER CERTIFICATION APPROVED BY MEDICAL physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be $\angle 3_4$ ≥ 7 Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death g Unknown а Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stanosis 1 Yes 2 No 3 Probably 4 Unknown Depondence 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Pyes 2 Pane director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)
t 28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number MD. son who completed cause of death (Item 23a) (Type, Print) 30. Name and address df pg Ave Baltimore, ounc

DHMH 17 Rev 7/2009

State

Registrar

37. Registrar's Signatu

Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g920 10-12-11vt

For State of Manyland / Department of Health and Mental Hygiene 0 | | |

Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8 A French 201 Helen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 1928 9. Birthplace (State or Foreign Funeral 1 M 2 D 82 Director 213-26-6489 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1719 Brookview Road 21222 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian or j Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White "natural", Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Time Clerk Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be William Edward French Margaret Mary Roche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emilia A. Ciocchi niece Page 1 and 2 624 S. Lakewood Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 16, 1 XXBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 2011 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmune Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 youths? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by idnei 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy 25. Was case referred to medical examiner?

1 X Yes 2 140 completed filled in by the funeral director, 26. Place of Death (Check only one) Be Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 🗆 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in my and the cause of examination and t 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Desal 30 NINTAN 31. Date filed (Month, Day, Year) State JUL Registrar

DHMH 17 Rev 7/2009

11-05697 Anthony Frenkil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physici edical Exami		Decedent's Nam ANTHON		Last)	FREN	TK T T				2. Date of Dear Month July 30, 20	Day Vo	ar	3. Time of Death 0754 hrs
		4a. Facility Name ((if not institution,	give street and number			ity, Town,	or Location	of Death	July 30, 2	4c. County	of Death	
_			Street Apt. 5				altimore	Lun		10.0	N/		
Funeral Director		5. Social Security 1 214-50-	5410	7. Ag	e (In yrs. I	M	Under 1 Ye	ays Hours	er 24Hrs. s Min.	08/05/	th(MM/DD/YYYY /1945	Foreig	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Na	1000	CE/DAUGHTE	D	19b. Mailing Add					nber, City or Tow DGE , MD	n, State, 2.1 (
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/Medical Examiner			nly one cause or (Final disease		Cardiov	ascular Disease							Between Onset and Death
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P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Medical	UNPENDED		AMENDED									
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On C cending sath. or: Af	rtion	1 Natural	5 Pendin	(Month, Day,Y	aar)			Yes 2					
Divisi tal or Att us after de tal Direct	Certification:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determ	28e. Place of In	jury - At h	ome, farm, street, fac	tory, office	building, et	c. 2	8f. Location (S or Town, S		er or Rur	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Happital or the transfer of the Happital or the transfer of the Happital or the transfer of the Happital or the Functal Brack of the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.	edical C	29a. Certifier (Check only		sician: To the best of m									
T S	Me	29b. Signature and	title of certifier	and manner stated.			29c. Licer	se number			29d. Date sign	ed (Mon	th, Day, Year)
			YN	1/1			0.0	.M.E.			July 31, 20	11	
		30. Name and addr	/	fo completed cause of d ty Chief Medical E			nore Str	reet Balti	imore M	MD 21223			
S	ate	31. DALLIGU (Port		32. Register				Joe, Dall		1223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24673 Certificate of Death 3. Time of Death 7 2. Date of Death Physician/ 201 Medical 4c. County of Death Facility Name (if not institution, give street and name cocation of Death **Examiner** N/A 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 **Funeral** Months Min 218-38-4000 Hours Ma**YCH**, D111 Year 1943 68 Mary Tand Director Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Examiner must be notified 1 ☐ Yes 2 🔀 No Annapolis Anne Arundel Maryland 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 1489 Bridgewater Way 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I once. Commercial Banking Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Virginia Rans Fisher Ernest W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Maryland 1489 Bridgewater Way Wife Laurie Fisher 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-2-2011 Maryland Towson 22. Name and Address of Facility Ruck Towson Funeral Home, neral Service Licensee Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer set and Deal Immediate Cause (Final Physician/ marile disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a considuence of: Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital မ ER/Outpatient 3 DOA 1 npatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pendina within 24 hours atter deaun.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

outer 245 Sr. Paul Pl

ss of person who completed ca

3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Filipidis 10:00 Helen L. Julv 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Forest Hill Heart Heritage 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Country Maryland Days (Month, Day, Yea 1 🗆 M 2 🔀 F Hours 89 215**-**14-4874 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2X No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21234 11 Carriage Lamp Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Restaurant Ow<u>ner</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vasilikie Pertissis James Lambros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Carriage Lamp Ct. Baltimore, MD. 21234 Irene Peltsemes/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Demetrios Cem. 8-3-11 Cub Hill, MD. Signature of Fineral Strvice Ucense Ruck Towson Funeral Home, 1050 York Rd. Towson, md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease Approximate Interval Between
Onset and Death shock, or heart failure. Ust only one cause on each line distM Immediate Cause (Final Cerebist Mountan resulting in death)

Pnysician/ Medical Examiner

Physician/

Medical

10a. State

MD.

Director

Funeral

Completed by

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Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Certificate: To

Medical

2 Accident
3 Suicide

29a. Certifier

(Check

only one

31. Date filed (Month, Day, Year)

Investigation 6 Could not be

NIGRAP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ary

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to or as a consequence of:	
Cause (Disease or iinjury that initiated events resulting in death) Last	c	
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition		co use contribute to the cause of death?
	24a. Was an autopsy performe 1 □ Yes 2 I	
25. Was case referred to predical examiner?	26. Place of Death (Check only one)	pssisted
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	e 6 Other (Specify)
7. Manns of Death 1 Natural 5 Pending		njury occurred

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

- W. MALPHAIL RD Bel DIR MD 21014

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 7/2009

State

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes and Legible.

		_	For State Registrar		State of Ma	aryiano	-	tificate of E		anu iv		Reg. No.	01		2467	75
	Physicia		Cladus C Cottu							⁄ear	3. Time of De	eath M				
	Medic Examin		4a. Facility Name (if n		4b. City, Town, or Location of Death			\neg	11 6:00 A [™] 4c. County of Death							
			437 Silver Run Rd.					Edgewate		Anne Arundel				- union		
	Funeral Director		5. Social Security Number 6. Sex 1 \(\text{ \subset} \) Age (In yrs. last birthday) \\ 116-36-6961 7. Age (In yrs. last birthday) \\ 1 \(\text{ \subset} \) Yrs. 1 \(\text{ \subset} \) Add the security Number \\ 1 \(\text{ \subset} \) Age (In yrs. last birthday) \\ 1 \(\s							9. Birthplace (State or Foreign Country) NY						
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L													
	B Mary	Director	MD Anne Arundel Edgewater 10e. Street and Number 10e. Citizer									1 Yes 2	XXNo			
	vith the	ral	437 Silver					10f. Zip Code	21037			10g. Citi	zen of Wh		itry?	
	items	Funeral	11. Marital Status	Kull Ku:	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi Yes, specify Cuba			cify Yes or No- Rican, etc.)	T.	14. Race -		an Indian,	
20	s after al", or Examir	d by	1 ☐ Never Marrie 3 ☐ Widowed 4		1 ☐ Yes 2XX If Yes, Give Year or Dates.	No		☐ Yes 2 No					Specify:	Whi		
The Never Married 2 Married 1 Yes 2X No Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16a Deceden						st of worki	rking 16b. Kind of Bus									
7	To be determined to be								Own Home							
מם	filed wall Hygard of othe	Be	17. Father's Name (Fi	rst, Middle, Last)	2			Tiolijeijiakei	18. Mot	her's Name	e (First, Middle,	Maiden S		iomo		
Maryland	Frank 0. W. Johnson Alma Erickson 19a Informant's Name/Relationship (Type Print) 19b Mailing Address (Street and Number or Pural Pourte Number of Pural Pural Pourte Number of Pural															
	2 shulth an 27 is	3	19a. Informant's Nan Donna L. F		pe, <i>Print)</i> Daughtei	. 1		g Address <i>(Street a</i> 1 ver Run R					Town, Sta	te, ∠ıp (Code)	
ore,			20a. Method of Dispo	osition	Removal from State			sition (Name of atory or other plac	e)		Date	20c. Lo	cation - C	ity or To	own, State	
Baltimor	permit, Page 1 Department of Important: If it any injury or o		4 Donation	5 Other (Specif	y)	Com	nmack Ce		i	Aug 9,		Comma	ack, N	ΙΥ		
g	perm Depa Impo any i		K. Gregor	erel Service Liver	M01148		22.	Name and Addres Fink Funer 426 Crain	a T Ho Hwy S	ome, P. G., Gle	A. n Burnie	, MD 2	21061			
	Ph _y sician/ Medical Examiner	er	23a. Part 1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure List only of inal	Due to (or as a	SCUL a conseque	AL I	the mode of dying			r respiratory ar	rest,			Approximate Interval Betwe Opset and Des	
if any, leading to immediate Due to (or as a consequence of):																
, Box 687	death certifi ne attending ed for use a		IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	opths?									ery Day Yea	ar		
л. О	requires that the been signed by the should be detach	ρ	Part II. Other signific	cant conditions co	ontributing to death b	ut not resul	Iting in the ur	nderlying cause giv	ren in Par	rt I.					he cause of deat	
Spuc	require been si should I	autopsy prior to completic death? 1 ☐ Yes 2 1 ☐ No. 1 ☐ Yes 2 ☐ Yes									14					
Records,	The law ate has bage 2									mpletion of cau	se of					
VITAL	ician: The certificate rector, pag	Be	25. Was case referred examiner?		Hospital:			Othe		eath (Check					HISDI	CEH
N OT V	To the Höspital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director,	cate: To	1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatle 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide determined					of 28c. Injury at 28d. Describe how injury				Other occurred	Yother (Specify) I JOSP I CONT occurred			
JIVISION	al or Atter s after dea I Director d in by the	Certificate:										on (Street and Number or Rural Route Number, Town, State)				
\	he Hôspit iin 24 hour he Funera pleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the caus								to the ca	use(s) and mann	er stated.			
h Uky Chr							29c. License number 207024				29d. Date signed (Month, Day, Year) 8 13 2011					
	(8)		30. Name and addre	s of person who o	completed cause of d	eath (Item 2	23a) (Type, P	JONTH C	HAR	LES	TOWS)N,	MAR	YL	AN 021	1204
	Stat Registra		31. Date filed (Month)	, way, year)	32 Registra	ars Signatu	1. 40	well								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month GIUNDSLSM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chapel Hill Nursing Home Baltimore Randallstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F Hours Director 517-14-9716 88 10-22-1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ı and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 No Director Baltimore Randallstown 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code Funeral 9612 Orpin Road 21133 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify þ 3 Widowed 4 Divorced WW II White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Director Commercial Credit years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David L. Gunderson Myrtle D. Brenden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. Elaine Gunderson (wife) 9612 Orpin Road Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-1-2011 Woodlawn, MD Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Approximate Interval Between Sheet and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ANCHANC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HEIMENS 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the form 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Datę signed (Month, Day, Year)

State Registrar

2835 Smith AUENUE \$203 pourious, Marylows 21209 naussne. JAMINA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSSS52_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 27 Day 201 Ta 10:47pm Physician/ Therese Giacomazza Megan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TOWSON GREATER BALTIMORE MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. Months Davs Hours Septenth, 6 ay, 1997 MaryTand 212-51-6461 13 **Director** Usual Residence of Decedent 10c. City, Town or Location Monkton 10d. Inside City Limits with the Maryland notified at Director Maryland Baltimore 1 Yes 2 No 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be. Funeral U.S.A. 21111 2055 Corbett Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc <u>ک</u> 1 🕅 Never Married 2 🗆 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, ည Michael Giacomazza Mary Alves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2313 Wuthering Road Timonium, Maryland 21093 Michael Giacomazza / Father permit. Page 1 and 2
Department of Health
Important: If item 27
any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gdns. 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Timonium, Maryland 8/2/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Sorric Licens 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ natural causes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner congenital hear t Secuentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day 5 Other (specify) Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 7/29/11 D0072156

Registrar

State

31. Date filed (Month, Day, Year)

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100

Charles st Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(070)

N.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland bepartment of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month ULV Physician/ Year 105 2011 . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Home Baltimore thera Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Min **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits must be notified Randallstow 3altimore 1 Yes 2 No 10e. Street and Number 8828 Sto ö 10g. Citizen of What Country? Funeral tems 23a renave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 9 Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. Ę Enginee 2th arade Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ illiam ucille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D Michael Providence Drive (Gooden ovination 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/08/2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Chattanooga, IN 08/06/12/11 Chattanooga Natil 4 ☐ Donation 5 ☐ Other (Specify) Cenetery 21. Signat re of Funeral Service Licenses 22. Name and Address of a cility Vaughn C. Greene Funeral Gervices Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart fail ure. List only one cause on each line. Immediate Cause Final BSTRUCTIVE Ph_sician/ ARDNIL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ri any, leading to inimediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Medical Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

28a. Date of injury (Month, Day, Year) 28c. Injury at work? Natural 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29a. Certi	fier 1	Certifying Physicia	an: To the best of my knowledge, death occure	ed at the time, date and place, and due	e to the ca	use(s) and manner as stated.			
(Che	ck 2	Medical Examiner	ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
only	опе) 3 🗌	Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
20h Ciana	third and title	of portifier A		00-1:		071 DA 1 144 W D W 1			

Mi BALID 21209 SUITE 203 HIIMES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2135

ASNE mi 32 Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SR. HOLMES FREDDIE JULY 2011 1:42 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PALMER PARK 7632 ALLENDALE CIRCLE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday. **Funeral** Months Hours Min 1 X M 2 □ F WASHINGTON, DC **Director** JUNE 1939 577-52**-**9535 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No PRINCE GEORGE'S PALMER PARK MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral be filed within 72 hours after death with USA 20785 7632 ALLENDALE CIRCLE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 1 XYes 2 ☐ No ARMY If Yes, Give Maryland 21215-0036 Specify: BLACK 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) n and Mental Hygien 7 is marked other tl POSTAL GOVERNMENT 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transoner. ည JAMES HOLMES ULYSSES LITTLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FREDDIE 1507 W CRANE POND MARION INDIANA 46952 HOLMES JR. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/9/2011 RIVERDALE, MARYLAND RIVERDALE CREMATORY of Funeral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Mane Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Coronari disease or condition Medical resulting in death) **Examiner** eriension Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rail director, page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) \(\text{Pesidence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pending Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.1) D48042 8/2/2011 Sarraru31

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

AUG 0 3 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tohummud Sartarazi S810 Valerian lane Rackville MD 20852.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:01 30 2011 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins HOSPITA HMOre If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Months **★** M 2...F KY 73 Feb 17, 1938 407-52-7168 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be realised at 1 ☐Yes 2 No Director Olive Hill KY Carter 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Hwy 60, Olive Hill, KY Funeral 20003 US 41164 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ∐Yes 2 ∏ No Yes, Gi**XX** 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2**XX**No ģ Specify: White 3 Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude P! Simer **Everett Anderson Hicks** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20003 Hwy US 60, Olive Hill, KY 41164 Daughter Kimberly Berryhill 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages
Department of I
Important: If its
any injury or o
once. 1 Burial 2 □ Cremation 3 Removal from State AUg 4, 2011 Watson Cemetery Olive Hill, KY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic K Gregory Fink 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ballure. List only one cause on each line. Immediate Cause (Final **Physician** SMALL CELL LUNG CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yea Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 2 s this certificate 1 Yes Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Box 68760. o σ. CDivision of Vital Records,

Baltimore, Maryland 21215-0036

ours after death. within 24 hours a

completely

To the Hospital or

29c. License number 29d. Date signed (Month, Day, Year)

600 N. Wolfe Street Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VISWANATHAN PRIYAA SRI SHANMUGA

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Medical

State Registrar 32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible.

eremy Wilson F		1- For State Registrar	artment of I rtificate of L		Hygiene Reg.	No. 201	1 2468
Physicia Medical Exami		1. Decedent's Neme (First, Middle,Last) Jeremy Wilson Karsten			2. Date of Death Month D July 28, 201	ay Year	3. Time of Death 1109 hrs
		4a. Facility Name (if not institution, give street and number) 6709 Manatee Court		. City, Town, or Location of Dea		4c. County of Death Charles	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year If Under 24H	Irs. 8. Date of Birth(I	MM/DD/YYYY) 9. Birt	
d anw any			, Town or Location	1			10d. Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a nr 28a-f shnw be notified at once.	Director	10e. Street and Number 6709 Manatee Court		10f. Zip Code 20603		Citizen of What Coun	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a nr 28a-f shor other traumatie event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes	Decedent of Hispanic Origin? (, specify Cuban, Mexican, Puer les $2 \left[\overline{X} \right]$ No specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amenic White, etc.	
6 172 hours aft an "natural'	leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's during mos	Usual Occupation (Give kind of tof working life. DO NOT use re	etired)	b. Kind of Business/Ir	
21215-0036 Muld be filed within 72 hos Mental Hygiene. marked other than "nas	Be Completed	5+ 17. Father's Name (First, Middle, Last) Jerry Karsten	Food S		ne (First, Middle, Maid Randolph	FOOd den Surname)	
MD 21; ad 2 should be alth and Men an 27 is mar aumatic eve		19a. Informant's Name/Relationship (Type, Print) Jerry Karsten	319 W∈	ddress (Street and Number o	r Rural Route Number IMee, Ohio	43537	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med.		1 X Burial 2 Cremation 3 Removal from State	crematory or other ghland Me	emory Gardens	8-4-11 V	Oc. Location - City or Vaterville	,Ohio
Physician		Mulacl P. Morculle 23a. Part I. Enter the disease, or complications that caused the death	600	ne and Address of Facility M 9 Harford Road mode of dying, such as cardiac	,Baltimore	Maryland,	21214 Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the control of t					Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse Olesseo or injury that initiated				-	
cuted nd transit		events resulting in death) Last Due to (or as a consequence o	•				
50, te be executed sysician and burial - transit	edical			r me,g918 8-4-1			
certifica nding ph	-≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the Live birth 4 Pregnant at time of de	2 Fetal	death 3 Ectopic pregi		23d. Date of delivery Month Da	ay Year
s, P.O. B ires that the de signed by the	Ď	Part II. Other significant conditions contributing to death but not re	esulting in the und	lerlying cause given in Part I.		No 3 Proba	
of Vital Records, ig Physician: The law require ther this certificate has been si neral director, page 2 should be	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of 2 No
/ital Reoriem: The nis certificate director, page	å	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Check		sidence 6 🗸 Other:	Scene
ion of tending Ph	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) fd 7-28-11	28b. Time of Inju	ry 28c. Injury at Work?	28d. Describe how Unknown	injury occurred	
Division To the Hospital or Attent within 24 hours after death Th the Funeral Director: completely filled in by the	Certification	3 Suicide 6 X Could not be determined (Specify) A Re	esidence		or Town, State Waldorf, M	6709 Manat	
To the Howithin 24 h Th the Fur	Medical	Check only one) 2 Medical Examiner: On the basis of examination and manner stated.					
	ž	29b. Signature and title of certifier Club C Hallan		29c. License number O.C.M.E.		d. Date signed (Moni	th, Day, Year)
		30. Name and address of person who completed cause of death (Item Carol Allan, MD Assistant Medical Examiner	,	ore Street, Baltimore, M	MD 21223		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Refisheds Signatu	A La	W			
DHMH 17 Rev 1/20		,	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g917,07/29/2011 dhb Certificate of Death Reg. No. 1 - For Amend Item 25
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 6:20 PM 101 4a. Facility Name (if not institution, give street and number) Ó Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number If Under last birthday Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 **X**M 2 □ F Months Days Min. 219-07-45 Director Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Armon If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married ò ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: Specify. "natural", Completed 3 Widowed 4 ☐ Divorced ni 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NO1 use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 101 traumatic event. Be 17. Father's Name (First, Middle, Last) שווא אור 18. Mother's Name (First, Middle, Maiden Surname, ပ Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau M 2/12)9190H 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ink 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 ☐ Other (Specify) 18434 21. Signature of Fun Licensee 22. Name and Address of Fa essup, PA 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Pause (Final disease or condition Onset and Death Ph_sician/ 10 day Medical resulting in death) Examiner 10 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last PROVED BY MEDICAL EXAMINER Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia CERTIFICATIO Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) , MD AT 1438946 Mulumer IIG. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMED JASAREVIC, UNION HEHORIAL HOSPITAL, 201 E-UNIVERSITY PARKWAY, BALTIMORE, MD 21218

DHMH 17 Rev 7/2009

State

Registrar

anko

Registrar's Signature

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day KerTha Kea 8:45P 2011 Medical Juli 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Randallstown Seasons Hospice Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 F Month, Day, Hours 21.7-20-4280 **Director** 85 Usual Residence of Deceden 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fath if item 27 is marked other than "natural", or items 23a or 28a-f sho lart; if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore 1 💢 Yes 2 🗌 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4210 Fairview Avenue 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: African-American 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene.
ad other the Elementary/Seconday (0-12) College (1-4 or 5+) 4 Springfield HospitalSt. of MD Nurse Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hass Evans Charlottie Walston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace Evans/Son 2061 Northeast Avenue Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 8/1/2011 Baltimore, Maryland 21. Signature of Furreral Seffvice Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto.Co. 2 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CardioThrombotic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** cardiorasiular Disease Atherosclembic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death n signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has performed After this certificate 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home } 5 \(\text{Residence } 6 \(\text{M} \) Other (Specify) 1 🗆 Yes 2 🗹 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nský apalneM.D 00057465

DHMH 17 Rev 7/2009

State Registrar 5 min

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32. Registrar's Signature

5-703

Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rajapailse M.D

N - S Kg 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24684 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 3:15 PM M Joseph William Kilroy 07 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightview of Bel Air Harford Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign .Sex 1. XM 2. □ F **Funeral** Months Days Hours Min. 03/31/1925 Director Massachusetts 028-12-5749 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2X No MD Harford Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2804 Brockway Place U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates. WW II Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Marble and Tile 12 4 National Sales Manager Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Josephine (Unknown) Joseph W. Kilrov Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17070 608 Robins View Lane - New Cumberland, PA Deborah Miller (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 08/02/2011 | BAltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assala 11750 Belair Road - KIngsville, Marylad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. end sta Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 No 9 Unknown g Unknown P.0 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Assisted Living Hospital 1 ☐ Yes 2 ☐ No. 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d Date signed (Month, Day, Year) Down 5 D32255 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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			For State of M	laryland / Dep Ce	partment of Hertificate of D			iene leg. N 2011	24685
	Physicia		1. Decedent's Name (First, Middle, Last) James Kimble				2. Date of Dear Month		3. Time of Death
9	Medic Examin		4a. Facility Name (if not institution, give street and number) University of Manland Medical	al Center	4b. City, Town, or 1		Ang	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2 1 F	ge (In yrs. last birthday, Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day, Dec. 6,	9. Bi Year) Co 1953 Ma	rthplace (State or Foreign ountry) ryland
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel	10c. City, Town or L	ocation idena		_		10d, Inside City Limits 1 ☐ Yes 2 ☑ No
	n the Ma a or 28a be notif	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
	h with ms 23 must	ner	888 Longview Ave.		2112			USA	
9800	ge 1 and 2 should be filed within 72 hours after death with the Manyland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Armed Forces, 1 ☒ Yes 2 □ If Yes, Give Year or Dates.		. Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036	thin 72 hou ene. than "natu he Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	5+) (Give	edent's Usual Occupa e kind of work done do DO NOT use retired)	uring most of worki	ng	16b. Kind of Business	Public Sch.
d 2	led wi Hygid other ent, t	Be (12 17. Father's Name (First, Middle, Last)		rounds ma:	18. Mother's Name	e (First, Middle, I		Fubile Sell.
ylan	ld be fi Mental arked atic ev	욘	Paul	Kir	nble	Shi	rley		Keyser
, Maryland	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Shirley Kimble mother	I	ling Address (Street at 388 Longvi			City or Town, State, Z	(ip Code)
Baltimore,	Page 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	7	oosition (Name of ematory or other place ematory Inc)	Date 2011	20c. Location - City of Baltimore	
Balti	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signatura of Fugeral service Litters e		22. Name and Address	s of Facility St	_	Funeral Hosadena MD	
***	Ph_sician/		23a. Part N Enter the disease, or complications tha cause shock, or heart failure. List only one pause on each lir Immediate Cause (Final	ed the death. Do not en	nter the mode of dying	, such as cardiac c	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Medical Examiner		requities in death)	a consequence of):					
	ted nsit	miner	cause. Enter Underlying Cause (Disease or iinjury	а боловушелов Оў.					
0	ate be executed hysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as	a consequence of):					
68760	ificate ng phy as the		IF FEMALE:		-				
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b, Was decedent pregnant 23c. If yes, outcome 1 Live Birth	2 Fetal death 3 at time of death 5	Cother (specify)	/		23d. Date of d Month	elivery Day Year
ls, P.O.	uires that the signed by Id be detact		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause give	en in Part I.		bacco use contribute	to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law require ate has been si page 2 should	Completed by					24a, Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of
alF	iician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			ce of Death (Check		2,4110	00 2 2 1.10
f Vii	Physicia this cert al direct	မ	Hospital:	tient 2 ER/Outpati		4 L Nursing Ho		ence 6 Other (Spe	ecify)
o uc	ath. r: After ie funer	icate	1 ☑ Natural 5 ☐ Pending (Month, D. 2 ☐ AccidentInvestigation	ay, Year) injury	work's	Yes 2 No	28d. Describe n	ow injury occurred	
Divisio	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:		jury - At home, farm, s tc. (Specify)	treet, factory, office		28f. Location (S City or Tow	treet and Number or Fi n, State)	Rural Route Number,
_	e Hospit 24 hour e Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inve	estigation, in my opinior	n, death occurred at	the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	To the within To the comp	_	29b. Signature and like of certifie		29c. License			29d. Date signed (Mor	_
	~		The like MD		, , ,	.4469			2,2011
J	(V)		30. Name and address of person who completed cause of Sarah Dickinson, 2	2 S G	eene Stre	æt, Ba	Himore	MD -	21201
	Sta Registr		31. Date filed (Month, Day, Year) 32 Tegrist AUG 0 3 2011	rar's Signature	ake				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 540 AM 201 George Kuemmert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE PARK CATONSVILLE SUMMIT 8. Date of Birth (Month, Day, Year) Aug 8, 1917 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🛛 M 2 □ F Maryland Aug **Director** 93 214-01-1476 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "---any injury or other than 100. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Randallstown MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 21133 USA 3425 Chapman Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Anved Forces? 1 Yes 2 If Yes, Give Black, White, etc 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Lockheed Martin airplanes unk unk Be 18. Mother's Name (First, Middle, Maiden Sumame) $\, unk \,$ 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Cole – friend 4315 Wilkens Ave Apt A; Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 □ Donation 5 □ Other (Specify) in state 21. Sign ture 1, nera 1, e. 22. Name and Address of Facility State Anatomy Board freetor 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SENILITY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Examine Due to (or as a consequence of): Cause (Disease or linjury The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed NA 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) after death. Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 \square Pending 1. Natural Division 1 🗌 Yes 2 🗐 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING D0056948 JULY 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 AVE SULTE 204 BALTIMONE

DHMH 17 Rev 7/2009

State Registrar TANSINDA

31. Date filed (Month, Day, Year)
AUG 0 3 2011

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per TNF G918 8/09/2011 JH amend #19fate of Maryland / Department of Health and Mental Hygiene 24687 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 31^{Day} JULY 2011 JOSEPH J KAUFMAN 9:32 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 3307 NORTHBROOK ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours 1270271929 **Director** 214-26-8622 81 MN Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic acceptant. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3307 NORTHBROOK ROAD 21208 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 🗆 Widowed 4 🗆 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) COMMERCIAL Elementary/Seconday (0-12) College (1-4 or 5+) BROKER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KAUFMAN MAX LOUISE ROSENTHAL 19a. Informant's Name/Relationship Type, Privile Gertrude B. Kaufman/Wife TRUDY KAUFMAN/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 NORTHBROOK ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM.: 08/02/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Lein ratt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ disease or condition ovonavu Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transil Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 XVo Yes 1 🗌 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 4 Nursing Home 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury Matural 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation Director: 2 Accider
3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) 10765 Talls therville MD 21093 istrar's Signature AUG 0 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Trem 10c-per fh. 9918 8-3-11 sm State of Maryland Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2011 30 Frank /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, OI DS 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 358.44.1504 1 XM 2 □ F TL **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore **Funeral Director** Gwynn Oak 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number items 23a or 207 2122 Novthland Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Black Baltimore, Maryland 21215-0036 Specify: Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helena Clark Jemi Lockhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road Guym Oak, MD 21207 2122 Northland Mildred Olivia Longstreeti WITE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD permit. Page Department or Important: If any injury or Woodlawn 08/06 2011 Cemetery 4 Donation 5 Other (Specify) Vaughin C. Greene Flureral Sesvices 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vau 8728 Liberty Road Kardallotum MD 21133 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, and as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death congestive hear ailure Immediate Cause Fina **Physician** disease or condition resulting in death) /Medical Due to (or 19 a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 3 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 1 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 2 Accident 5 Pending investigation Injury 1 Tyes 2 No death. after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 4 Homicide e Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 0

3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year Physician/ Lohman 2:00P Harold JULY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death® **Examiner** Baltimore 475 Torner Road Essex Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Yrs. Kentucky Director 89 407 16 1180 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗐 No Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 United States 475 Torner Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by 1 XXYes 2 ☐ No If Yes, Give Year or Dates. 1 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: 3 😾 Widowed 4 🗌 Divorced Completed White 1941-43 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehelm Steel Corp 12 Steel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Della Freedman Scott Edwin Lohman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Crisfield Road Middle River, Maryland 21220 Judy Lisa (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, □ Donation 5 □ Other (Specify) 8/4/2011 Baltimore Maryland Oak Lawn Cemetery ^{22. Name and Address of Facility} Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 1. Enter the disease, o k, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. prostate cancer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease of Injury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an or Attending Physician; The law page 2 s autopsy performed? Yes 2 No this certificate has 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapalise M.D DOUS7 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

AV-

SMITH

2835

32. Registrar's Signature

N. S Rajapakse, M.D

31. Date filed (Month, Day, Year,

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21209.

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		-	- State Amend Item	State of Maryland n 10e per sa.,ç	d / Depa 1918-0 8	rtment of F 1/03/2011 Ificate of L	lealth and Mo dhb Jeath	ental Hygie Reg	2011	24690
	Physicia	n/	1. Decedent's Name (First, Middle, Las Jeanette Louise	•				2. Date of Death July	20 2011	3. Time of Death 3:50 AM
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	July	4c. County of Death	
	j	٠.	226 Timberline	Circle		Berlin	1		Worces	ter
	Funeral Director		143-22-3031	ex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth eb 2, 19	9. Birt Co.	hplace (State or Foreign Intry) ew Jersey
7	aryland ka-f show ified at		Usual Residence of Decedent 10a. State 10b. County MD Worce	·	, Town or Loc erlin	ation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
UNC+	with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number 226 To Whiteherse	imberline Circl	le	10f. Zip Code 21811		10	g. Citizen of What Co	untry?
Garage Services	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marrled 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If	/as Decedent of Hi Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
	nin 72 hou ne. :han "natı e Medica	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give k life. DC	NOT use retired)	ation Juring most of working	g 10	6b. Kind of Business I	
), 	ntal Hygier ntal Hygier ed other i event, th	a	12 17. Father's Name (First, Middle, Last) Emile Joseph Ju	0	hou	sewife	18. Mother's Name		own home	2
20 UU (12 should be alth and Menti 27 is marked r traumatic e		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin 86	g Address (Street a Whitehor		Route Number: C	ity or Town, State, Zip 21811	Code)
LI L Baltimore,	Page 1 and nent of Hed ant; If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci	Removal from State	emetery, crem	sition (Name of atory or other place	э)		Oc. Location - City or	Town, State
Balti	permit. Departin Imports any inju		21. Signaturu Suneral Service Licens	Wast, Director	22.		s of Facility Sta altimore		my Board imore, MD	21201
* Than y	Physician/ Medical Examiner	er	23a. Party. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused the death ne cause on each line. a. Due to (or as a consequence) Due to (or as a consequence)	ence of):	0	g, such as cardiac or		,	Approximate Interval Between Onset and Death
092	cate be executed physician and s the burial-transit	edical Examiner	rany, leading to finincial cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	cDue to (or as a consequ						
<i>δ</i>). Box 687	the Hospital or Attending Physician: The law requires that the death certifich hin 24 hours after death. the Funeral Director. After this certificate has been signed by the attending impleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 254 No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
7/0e/26 ords, P.O.	quires that I en signed b uld be deta	ed by P	Part II. Other significant conditions o	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
جوبرے Division of Vital Records,	n: The law red icate has be r, page 2 shc	Completed by	OF Was assessed to send as					24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
/ita	rsiciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes No	Hospital:	ER/Outpatien	Othe	ace of Death (Check on the chart of the char	V	ce 6 Other (Spec	(6.1)
of	ng Phy ter this neral o		27. Manner of Death Natural 5 □ Pending		28b. Time of injury	28c. Injury work	at 28	3d. Describe how		
ivision	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has lacompleted filled in by the funeral director, page 2 or many than the funeral director, page 2 or many than the funeral director.	Certificate:	Accident Investigatio Suicide 6 Could not b Homicide determined			M 1 🗆	Yes 2 No	8f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
۵	ne Hospital n 24 hours ne Funeral bleted filled	Medical	(Check Medical Exam	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or invest	gation, in my opinio	n, death occurred at t	he time, date and	place, and due to the	cause(s) and manner stated.
	To the within To the company of the		29b, Signature and title of certifier	000	MN)	29c. License		-	Date signed (Month	
_			30. Name and address of person who	MO COASTAL	-Host	TILE P	OBOX17	233 54	JUEBURY,	MD 2/802
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 3 20	32/ Registrar's Signat	. Spa	KN				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yuty 20 2011 9:00 P_M Constance J. Lindyberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Glen Meadows Retirement Community Glen Arm 8. Date of Birth
(Month, Day, Year)
May 7, 1918 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🗓 F New York 93 Yrs Director 064-05-3195 May Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11630 Glen Arm Rd. 21057 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file f Health and Mental F item 27 is marked o ပ Leokadia Szpanowska Jan Ojrzynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Vincent Lindyberg - husband 11630 Glen Arm Rd; Glen Arm, Maryland 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Sign Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NS ysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **X**No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 29c. License number 21 2011

State Registrar 30 Name and address of person who completed cause of de KAMAHA A GOPALAH

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IVELY RANCES 0930AM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17 Enchanted Hills Road, Apt. 2 Baltimore Owings Mills Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 29, If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign 213-20-2978 1 □ M 2 🛛 F Days Hours Country)Maryland Director Usual Residence of Decedent 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 🖺 No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Enchanted Hills Road, Apt.2 21117 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 12 College (1-4 or 5+) Owner-Self-Employed Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George Jackson Ecca Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Okima Pompev Enchanted Hills Road, Apt. 2, Owings Mills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation, Inc. 8-4-11 Hanover, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licensee muhan 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nd Zoos disease or condition resulting in death) Medical Examiner ZOII Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a onsequence of) the Funeral Director: After this certificate has been signed by the attending physician and poleted filled in by the funeral director, page 2 should be detached for use as the burial-transit 12011 Due to (or as a consequence of) resulting in death) Last Physician/Medical 2000 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth
Pregnant in the past 12 months? Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director, After this certificate Dan 2 🗆 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar

31 Date files (Month Day Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R131119

29d. Date signed (Month, Day, Year)

08-01-2011 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24693 State
 Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Little R. Juny 201T 2:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City. Town, or Location of Death Timonium Stella Maris 7. Age (In yrs. last birthday) 87 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F MaryTrand 216-14-8456 Months Days Hours Mayorth2229, Year 924 **Director** Usual Residence of Decedent , or items 23a or 28a-f show iminer must be notified at 10b. County 10c. City, Town or Location Lutherville 10d. Inside City Limits Directo Mary land Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1802 Dulaney Valley Road 21093 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. ed other than "natural", or iter event, the Medical Examiner 14. Race - American Indian, Armed Forces? Black, White, etc ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)
Office Manager Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Schuckert Miller George Charles R. Louisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Dulaney Valley Road, Lutherville, Md. 21093 Charles Little / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State Most Holy Redeemer Cemetery 8/1/2011 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Other (specify) Month Day Year Pregnant at time of death g 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause cf death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

JACKIE

31. Date filed (Month, Day, Year)

JONES,

AUG 0 3 2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:50P M 26,2011 Year July Physician/ Larry Arthur Miller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Hyattsville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) . Sex 1 🛛 M 2 ☐ F Columbia **Funeral** Days Hours 216-50-8163 63 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Prince George's Bladensburg Direct Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 20710 4102 53rd Avenue, Apt. 2 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 XNever Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry Delivery Man Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Eleanor M. Harris Arthur E. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6034 Fair Oakes Drive, Frederick, Maryland 21703 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ronald C. Miller 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland 7-29-11 Ardent Cremation, Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licen 6009 Harford Road, Baltimore, Maryland chae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatic Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months?

1 Yes 2 No been signed by the should be detached 1 ☐ Yes ∠ L 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Encephologiath 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Menato-Renal 24a. Was an autopsy this certificate has ral director, page 2 performed? Yes 2 N 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital funeral director. Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 27, Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of Certificate: eral Director: After filled in by the funer Natural
Accident 5 Pending 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 3 Certifying Nurse Practioner: To 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 2011 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE Jaseleep Singh

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24695 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 29, 2011 JAMES JOSEPH MCADAMS PM 5:48 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 608 CAROLYN RD. ANNE ARUNDEL **GLEN BURNIE** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, Birthpia Country) **PA Funeral** Days Hours 1**XX**M 2 □ F Months APRIL 17. 196.26.7994 76 Yrs Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🔭 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 608 CAROLYN RD. USA 21061 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XXYes 2 No If Yes, Give Year or Dates. 1956-61 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. er than "natural", the Medical Exa Specify: 3 Widowed 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NSA NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JAMES JOSEPH MCADAMS FRANCIS DELORES MCKEOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MCADAMS WIFE 608 CAROLYN RD, GLEN BURNIE, MD 21061 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BAYVIEW CREMATORY INC AUG 1, 2011 BALTIMORE, MD 4 Donation 5 Other (Specify) Sign rura of Funeral Service Li 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW CLEN BURNIE, MD 21061 CRECORK FINK M01148 23a. Part 1. Enter the shock, or heart fa nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cancer den ou disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the Unknown g 🗌 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this thin 24 hours after death.

o the Funeral Director. After th 28a. Date of injury (Month, Day, Year) funeral 27. Manner of De It Certificate: 28b. Time of 28c. Injury at Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

305

istrar's Signature

39505

Hospital IV, Glan Burne,

2011

1- For State Registrar Physician/ cdical Examiner A. Facility Name (if not institution, give street and number) Howard County General Hospital 5. Social Security Number Certificate of Death MAUDIEL MARROQUIN A. Facility Name (if not institution, give street and number) Howard County General Hospital Columbia Reg. No. 2. Date of Death Month Day June 27, 2011 4b. City, Town, or Location of Death Columbia Howard Columbia Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY)	3. Time of Death 0005 hrs
Addical Examiner MAUDIEL MARROQUIN June 27, 2011 4a. Facility Name (if not institution, give street and number) Howard County General Hospital Additional Marroquin Marroquin June 27, 2011 4c. County Columbia Howard	o005 hrs
Howard County General Hospital Columbia Howard	
E Copiel Cognitive Number G. Cov 17 Ann (In use last highthour) If Under 1 Vans If Under 2/Line R. Date of Bighthamann	
Months Davis Min	Y) 9. Birthplace (State or Foreign 7 B Country) SALVADOF
214-61-0048 1 M 2 F 38 Yrs. Danuary 17 197	/B country) SALVADOR
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	1 X Yes 2 No
MD BALTIMORE GWYNN OAK 10e. Street and Number 10g. Citizen of W. 10g. Citizen of W. 21207 EL SALVA	
MD BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of W. 10f. Zip Code 10g. Citizen of W. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race White	ADOR e - American Indian, Black,
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race White 15. No 16. No 17. No Press 2 No 17. No Press 2 No 18. No Press 2 No 19. No Press 2 No Press	te, etc.
3 Widowed 4 Divorced If Yes, Give Yeer VE 2 No specify: SALVADORIAN Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Bu	WHITE usiness/Industry
Elementary/Secondary (0-12) College (1-4 or 5+)	asiness/industry
15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work during most of working life. Do Not use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
MD BALTIMORE GWYNN OAK 106. Street and Number 107. To per 1988 and p	
Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) (Brother)	
19a. Informant's Name/Relationship (Type, Print) (Brother) (Brother) (Brother) (Brother) (Brother) (Street and Number of Rural Route Number, City of Town and Country Ellicot City Name of Cou	MD 21043 - City or Town, State
The state of the s	pan, El Salvado:
4 Donation 5 Other Specify: 121. Signature of Funeral Service Licensee 222. Name and Address of Facility Santa Cruz Funeral 600 Kennedy ST, NW: Washington, DO	l Services, Inc
1) Tuncoffer of order	
failure. List only one cause on each line.	Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Complications of cardiac Arrhythmia Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated c.	
events resulting in death) Last Due to (or as a consequence of): d. AMENDED 23a-b,27,per me,g918 8-19-11 sm	
☐ AMENDED 23a-b,27,per me,g918 8-19-11 sm	
Use Mass decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of Month 2 Fetal death 3 Ectopic pregnancy	f delivery Day Year
79 2 3d. Date of pregnancy 1	
The state of the significant conditions are contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ribute to the cause of death?
1 Yes 2 No 3 24a. Was an autopsy	Probably 4 V Unknown
24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
The state of the s	Yes 2 No
The state of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 1 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6	Other:
1 Ves 2 No 1 Paraller 2 Exodupation 3 DOA 4 Nursing Home 5 Residence 5 2 27. Manner of Death (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occur	теd
Natural 5 Pending Investigation 22 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 1) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 2) 28f. Location (Street and Number 2	per or Rural Route Number, City
The stand of the s	oci or real reals realizer, ony
日本 日	er as stated. due to the cause(s)
and manner stated. 29c. License number 29d. Date sign	ned (Month, Day, Year)
O.C.M.E. July 27, 20	011
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
N Y	
State 31. Date filed (Month, Day, Year) Registrar AUG 0 3 2011 32. legistrar's Signature	

Registrar DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Physician/ Ju Medical city, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** PSL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** Days Hours Min d9 93 Months Mafferth, 13", 1918 HeadWatters, Virginia 332 9474 Yrs **Director** Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Svkesville Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 Copperidge 710 Olbrecht Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: "natural", 3xx Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Housekeeping-Own Home Housewife is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susan Crummett Arlev Jackson Botkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10527 Hounslow Drive Woodstock, Maryland 21163 19a. Informant's Name/Relationship (Type, Print) Clyde A McKinney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of harmonic of harmonic line and injury or other 1 X Burial 2 Cremation 3 Removal from State August 3 2011 Baltimore, Maryland Holly Hill Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Live 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease complications that caused the Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death ned by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 ☐ Yes 2 No

set and Death S

Registrar DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene 23a per dr.,9918,08/03/2011 dhb Certificate of Death 24698 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00 Month Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hospita Gene If Under 1 ast birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8, Date of Birth **Funeral** 1 M 2 F Months Hours Min. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Himore Yes 2 No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Yes, Give Year or Dates. Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black Maryland 21215-003 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) DUO ervisor Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname) 0 Department of Health and Meni Important: If item 27 is marke any injury or other traumatic ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aranddaughter Bato. MU 21215 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other 1 D Burial Cremation 3 - Removal from State Catonsville, mb 4 Donation 5 Other (Specify) 21. Signatur her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, of heart failu Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) ue to or as a consequence of Lung Cancer Stage IV Examiner DURATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Congestive Heart Failure as a consequence of): dinavni -tran and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ √Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autonsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 3. メーク Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completed filled in by the for Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my collision death accounted at the cause (s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Prantioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 39668 07 231 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Linden

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 2perPHYS, G918, 87372011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registral Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0 udrey Marter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Perring Pkwy If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Director March 23,1929 Pennsylvania 171-24-0006 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Examiner must be notified at once. 1 ☐ Yes 2 ☐ XNo Director Md. Balto. Nottingham 10g. Citizen of What Country? 10e. Street and Number 21236 9410 Dana Vista Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√€ No Specify. þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry A. Hydorn Ruth E. Warner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9410 Dana Vista Road Nottingham, Md. 21236 Keith Martin Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Md. Atlantic Crematory 21. Signature of Fun Pervice Li 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Payr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final oronary artery desea **Physician** disease or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transi P.O. Box 68760. Physician/Medical attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached by No 9 Unknoy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an certificate has autopsy 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as deaded.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 21 Doulsman

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JULY Day 8,2011 Mary L. Miglioretti 8:00P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Towson Saint Joseph Medical Center Social Security Number 6. Sex Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Maryland 1 □ M 2 🛛 F Year) 922 Months Days Hours Min. Oct. 30 Director 217-18-5648 88 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified MD Parkville 1 ☐ Yes 2 🔀 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd. #1616 21234 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 🛛 Widowed 4 🗆 Divorced Specify: white Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Seconday (0-12) 12 College (1-4 or 5+) Statistical Clerk Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Gaetano LaPonzina Francesca Lombardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard Schaech 9317 Montego Avenue; Parkville, MD 21234 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation Nother (Specify) entendment Lorraine Park 8/1/2011 Baltimore, MD 21. Signature of Fundal pervice Life 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause the t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Approximate Interval Between Immediate Cause (Final 2 DAYS Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Examiner YEARS CRITICAL ADRTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or impury 10 YEARS CORONARY ARTERY DISEASE that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes Other: 1 🔼 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 2 🗆 No Accident Investigation Suicide 6 Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

32. Registrar's Signature

D0059711

OSLER DRIVE TOWSON, MARYLAND 21204

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 30m 2011 ear McNelis 11:45 A M Desmond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 14 M 2 □ F **Funeral** Months Days Hours March 23 Treland Yrs **Director** 89 240-48-0381 Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Timonium be filed within /2 Inc....ental Hygiene.
Inked other than "natural", or items 23a or 28 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 210 Belmont Forest Court, #102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygien 7 is marked other the Medicine Medical Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ O'Donnell McNelis Brigid permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 Maryland Niall B. McNelis 2321 Benson Mill Road Sparks, Baltimore, 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date Dutane or Disposition (varie or Dutane)
Memorial Gardens 1X Burial 2 Cremation 3 Removal from State 8-3-2011 Timonium Maryland 4 ☐ Donation 5 ☐ Other (Specify) og ture of Funds. Se vi 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ju (mon m disease or condition aus Medical resulting in death) Due to (or as a consequence of) **Examiner** ocondial Sequentially list conditions if any, leading to immediate cause. Enter Underlying cap Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Nonm sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 💆 2 No 1 🗀 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work's 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occum ed at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title Uly 30, 2011 haves St. Belto. Md 30 Name and address 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and ertificate of Death	2.0	11 21.702
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No U	3. Time of Death
	Physicia Medic		Kobra Hasandokht	Najibeh	June 27, 20	Year 7:15 AM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	4c. County	
1			406 Ridge Road, Apt. 1 5. Social Security Number 6. Sex 7. Age fin vrs. last birthda.	Greenbelt if Under 1 Year If Under 24 Hrs		ice George's
	Funeral Director		5. Social Security Number 6.0 Sex 1 \(\sum M \) 2 \(\overline{\text{N}} \) F 7. Age (In yrs. last birthday yrs. 1 \(\overline{\text{N}} \) M 2 \(\overline{\text{N}} \) F 92 Yrs.	Months Days Hours Min.	05/20/1919	9. Birthplace (State or Foreign Country) Iran
	T OM		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or 1			
	aryland a-f sh iied a	ctol	10a. State 10b. County 10c. City, Town or I 10c. City, Town or I 10c. City, Town or I	Greenb	elt	10d. Inside City Limits 1 X Yes 2 □ No
	or 28	Öİ	10e. Street and Number	10f, Zip Code	10g. Citizen of V	What Country?
	with t s 23a ust b	Funeral Director	406 Ridge Road, Apt. 1	20770		Iran
	filed within 72 hours after death with the Maryland Hygiene. Alygiene. ad clygiene. do dether than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert		e - American Indian, ck, White, etc.
0030	s after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No If Yes, Give 9 Year or Dates.	1 ☐ Yes 2 🔀 No Specify:	Specify:	7.71- 3 4 -
5	hours	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation te kind of work done during most of wor	16b. Kind of Bu	usiness Industry
7	hin 72 ne. than '	mo:	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)		Homo
	filed wit al Hygie d other I event, th	Be C	6 17. Father's Name (First, Middle, Last)	Homemaker	ne (First, Middle, Maiden Surname	Home
land	l be fill fental rked ric ev	은	Abolhassan Hasandokht Najibeh	is. Modify of that	Naimi	,
Mary	ge 1 and 2 should be fill nt of Health and Mental til filem 27 is marked or or other traumatic eve		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Ru		
≥ oū̂	a. C N 5			10 Oak St., NW,		
0	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State cemetery, cr	position (Name of ematory or other place) purney Crem. 6/2	Date 20c. Location - 20c. Loca	- City or Town, State
Baltimor	permit. Page Department o Important: If any injury or once.		The Burnature of Dates (Opposity)	22 Name and Address of Facility		
ň	permit Depar Impor any ir once.	W. V	Double 4- Marshort	Maryland Cr PO Box 1413	emation Servi , Baltimore,	ices MD 21203
		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
-	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Heart fail	ure	Onset and Death
	Examiner		Due to (or as a consequence of): Hypertensy	re heart Du	501160	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		11	
	cuted nd transit	xam	Cause (Disease or iinjury that initiated events c.	Cardiony.	pathy	
	oe exe ician a ourial-	dical Examiner	resulting in death) Last Due to (or as a consequence of):	, 4	* (
	ath certificate be executed attending physician and for use as the burial-transit	ledic	d			
0 1	ending	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy	23d. Da	te of delivery
בַּבְ	deatr he att	Physician/Me		Other (specify)	Mo	onth Day Year
:	es that the des signed by the s I be detached I		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contr	ribute to the cause of death?
<u>,</u>	signe Id be	ed by			1 ☐ Yes 2 ☐ No	3 Probably 4 🔀 Unknown
ecords,	w require s been si	plete				Were autopsy findings available prior to completion of cause of
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0	ician; sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)	
5 i	Physic ruthis carral direction	∋: To	1 Yes 2 No 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of injury 28b. Time	ent 3 🗆 DOA 📗 4 🗀 Nursing F	lome 5XXResidence 6 Other	
5 :	nding lath. r: After e funer	icate	1 XX Iatural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	Edd. Sessings flow injury occurs	
IIOISIAIO	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
5	pital o		V		N .	1
7	Iorne hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death, and a start death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or involvedge only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred	at the time, date and place, and due	e to the cause(s) and manner stated.
: ب	Vithir Comp	~	29b. Signature and title of certifier	29c License number	29d Date signer	d (Month Day Year)
	,		physician	125087		06/27/2011
	\		30. Name and address of person who completed cause of death (Item 23a) (Type MOFIKPARA A WRIGHTM)	D 5082 Print) IIII Silver Spriw	9 St, # 21 9 8il	ver spring, no
Ī	Stat Registra		31. Date filed (Month, Day, Year) 32. Fegistrar's Signature AUG 0 3 2011	barker	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-05744 Dominic Perry State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da July 31, 2011 Perry 2157 hrs **Medical Examiner** Dominic 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdav) If Under 1 Year **Funeral** Months Days Min Hours Director 215-45-1637 28 95 Country MD 1 X M 2 F 80 Yrs 15 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore NA 1 X Yes 2 No MD 23a or 28a-f sho notified at once. I and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? U.S.A. 21229 630 Stamford Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes If Yes, Give Year Black 4 Divorced 1 Yes 2X No specify. Specify: Ď 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) eted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tant: If item 27 is marked other than 'or other traumatic event, the Medical School 21215-0036 Student ns 10th grade and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Deborah Edwards Dwayne Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 630 Stamford Road, Baltimore, Md 21229 Deborah Perry-Mother of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition timore. crematory or other place) 1 🛣 Burial 2 Cremation 3 Removal from State Pages 1 Woodlawn, Md King Memorial Park 8/9/2011 ent Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility March F/H West 4300 Wabash Ave, Bal E : Baltimore, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical AMENDED UNPENDED uttending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 ✔ No 3 Probably 4 Unknown σ. Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page 1 🗸 Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Hospital: 1 Other₄ Inpatient 2 ✔ ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jul 31, 2011 Subject shot 2120 hrs Natura Yes 2 🗸 No Pending filled in by the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) 1100 blk of Wedgewood Road, Baltimore, MD within 24 hours a To the Funeral I determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c License number August 1, 2011 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registra

31. Date filed (Month

OCME

egistrar's Signatu

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	Funeral		The Johns Hopkins Hos	7. Age (In yrs. last birth	day) If Under 1 Year	r If Under 24 Hrs. 8.	Date of Birth (Month, Day, Year)		nplace (State or Foreign intry)
	Director		Usual Residence of Decedent	M 2 XF 7 Y	rs.		1-5-195	10 Vi	MINIX
	aryland show i at	<u>_</u>	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1
	the Mir 28a-f	irecto	10e. Street and Number	1504	10f. Zip-Code	e	10g. Cit	tizen of What Cou	
	death with the Maryli ms 23a or 28a-f sho must be notified at	Funeral Director	2701 Mura S	treet	2/2	213	L	15A	in an Indian
36	after or ite miner	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specification) Hispanic Origin? (Specify: Specify:	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify:	rican Indian, a, etc.
21215-0036	should be filed within 72 hours and Mental Hygiene. s marked other than "natural", umatic event, the Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	Decedent's Usual Occi (Give kind of work done life. DO NOT use retire	e during most of working	16b. F	Kind of Business/	Industry
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Maryland	d 2 should th and Men 7 is marke traumatic	၉	19a. Informant's Name/Relationship (Type	Print) SON) 19b.	Mailing Address (Street	et and Number or Rural F	Route Number, City	or Town, State, Z	(ip Code)
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nore	8 5 1 1		20a. Method of Disposition Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Disposition (Name of y, crematory or other pl	(ace) 8/2	2011 (C)	ocation - City or	I-I G MA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral 5 e see	Marco 2	Vaugad Add	TOP LEAN	e Fune	w Se	roiter
ш	20 5 6 5		23a. Part 1. Enter the disease, or complice	ations that caused the death. Do no	ot enter the mode of d	YOCK KO yilg, such as cardiac or i	respiratory arrest,	alto N	Approximate Interval Between
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# × 68	certificate be nding physicia use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy				23d. Date of de	livery
£ 8	ath for	Physician/Medical	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnal 5 ☐ Other (specify)	ncy		Month	Day Year
五号	that the de ed by the a detached	y Phy	Part II. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause	given in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
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3ec	The law requate has been page 2 shou	Completed					24a. Was an autopsy performed?		utopsy findings available completion of cause of
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#3. Division of Vital Reco	e Hospital or Attendi 124 hours after death e Funeral Director: A letely filled in by the 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	m, street, factory, office	e 28	f. Location (Street a City or Town, State		ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directional Direction Completely filled in b	Medical (29a. Certifier 1	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the d/or investigation, in my	time, date and place, an y opinion, death occurred	d due to the cause(d at the time, date a	(s) and manner a and place, and du	s stated. ue to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			nse number		ate signed (Mont	
			* Staffing 1/2			5-000	Jul	y 22	2011
(2)			30. Name and address of person who con Geoffrey Tisc	5P1	(Type, Print)	600 N	orth Wolfe	St, Baltim	ore, MD, 21287
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	barker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 1 1

		For State Registrar		Ce	ertificate of			eg. N2011	24705
Physic		1. Decedent's Name (First, Middle, Las MOYSES		ISCH			Month	Day Year	P
/Medi Exami	ner	4a. Facility Name (If not institution, gives to the second of the second	e street and number	ALSIMORE (In yrs. last birthday, 79 Yrs.	BAL	r Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/17/1	4c. County of Dea	thplace (State or Foreign buntry) BRAZIL
Director		Usual Residence of Decedent					11/1//		
Marylaı f show	jo	10a. State 10b. County MD BALTIM		10c. City, Town or L					10d. Inside City Limits 1 □ Yes 2 No
th the I	Direc	10e. Street and Number	IORE	10WB	10f. Zip Code	-	10	0g. Citizen of What Co	ountry?
s 23a	eral	8415 BELLONA LA	NE, APT. 9		21204		ocify Vos or No.	USA 14. Race - Amo	orican Indian
Daltimore, Maryland Z1Z13-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Eventual must be notified at any injury or other traumatic event, Ite Madical Eventual any injury or other traumatic event.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 💆 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver iii 0.3.	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Ilspanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
21215-0036 d within 72 hours aff gjene. r than "natural", or	leted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	I (Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of work		16b. Kind of Business	/Industry
Z1Z Z1Z d withir giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+ 5+)	YSICIAN			MEDICAL	
and be file ntal Hy ed othe	Be	17. Father's Name (First, Middle, Last)	7.			18. Mother's Name	e (First, Middle, N		, EDMAN
Maryland of 2 should be file th and Mental Hy Z7 is marked oth traumatic event	은	PASCOAL 19a. Informant's Name/Relationship (IRISCH 19b. Mail	ing Address (Street	SARA and Number or Rur	al Route Number	, City or Town, State,	LERMAN Zip Code)
and 2 and 2 lealth a m 27 is		CAROLYN PURISCH	/WIFE					TOWSON, M	
nore ages 1 ant of H it: If Ite y or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specity		1	osition (Name of matory or other place I CEMETER	:	2/2011	20c. Location - City or OWINGS M	
baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or other		21. Signature of Funeral Service Lice	See WALL	2	2. Name and Addre	ss of Facility SOL	LEVINS	ON & BROS.	, INC.
		23 Part 1. Enter the disease, or compshock, or heart failure. List only	olications that caused to cause on, ach line	he death. Do not er	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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DOX sath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at i 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	у		23d. Date of de Month	l Blivery Day Year
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, st (Specify)		Yes 2 □No	28f, Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
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6		30. Name and dires of person who was Ala Tabin S.		ath (Item 23a) (Type	est Bel	vapare A	WE BOA	AMORE IN	0,2011
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar						

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9&19 Per ANA BD G918 8/03/2011 JH State of Maryland / Department of Health and Mental Hygien? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July $2^{6^{y}}$ 20ÎÎ 6:25 Ам Johnnie Peterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 21 Day, 1947 9. Birthplace (State or Foreign Country) THE Washington DC Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F Yrs **Director** 64 578-60-4682 Usual Residence of Decedent show 10c. City, Town or Location unk 10b. County unk 10a. State 10d. Inside City Limits the Maryland Director notified 28a-f 1 🗆 Yes 2 🗓 No DC. 5 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? must be Funeral 23a ۸ith USA 20019 5000 Nanny Burroughs Dr. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 12. Was Decedent Ever in U.S. 14. Race - American Indian, ral", or iten Examiner r Armed Forces?unk
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify "natural", 3 ☐ Widowed 4 ☐ Divorced Specify Completed Year or Dates Medical 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the unk unk ulth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411-K Health tem 27 Alexander Rhue - friend 34th Street SE. other 20020 Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other Specify) in State Ξ 0 Department of Important: If any injury or Ronald S. W. 22. Name and Address of Facility State Anatomy Soard Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ cardiac arrythmia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** hypertensive cardiovascular disease Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): -transit diabetes mellitus and that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the detached 1 ☐ Yes ∠ ☑ 9 ☐ Unknown 9 I Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 2 should peen 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No has prior to completion of cause of death? page After this certificate death? 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ophnell Cumberbatch 3001 Hospital Dr; Cheverly, Maryland 20785

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

275

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Mar State Amend Item 25 per me, g91 Registrar	rylang / 18,08/	Department of F 02/2011dhb Certificate of D	eaith and Mental Hy Death	/glen2 0	24707
	ı	Physicia		1. Decedent's Name (First, Middle, Last) Perella Virginia Pre2	ziosi		2. Date of Do Month	eath Day Year 5 201	3. Time of Death 1 12:00 AM
		Medic Examin Funeral Director		4a. Facility Name (if not institution, give street and number) Sinal Hospital of Balt 5. Social Security Number 213-32-9528 1 \(\text{M} \) 2 \(\frac{1}{8} \) F	*		Location of Death If Under 24 Hrs. 8. Date of Bit Hours Min. (Month D.)	4c. County of Dea N/A rth ay, Year) 9. Bi	ath
		Maryland 28a-f show notified at	rector	Usual Residence of Decedent 10a. State 10b. County 1 MD N/A	10c. City, Tov	vn or Location Baltimore			10d. Inside City Limits 1 Y□ Yes 2 □ No
		with the hs 23a or 2	Funeral Director	10e. Street and Number 3026 Oakcrest Avenue		10f. Zip Code 212	34	10g. Citizen of What C	Country?
J	9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates.	0	1 ☐ Yes 2 🙀 No		Specify:	white
perella	1215-	ithin 72 ho ene. r than "na the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 2 4		a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Homemaker	ation uring most of working	16b. Kind of Business At Home	s Industry
Per	land 2	be filed w ental Hygi ked other ic event, t	To Be	17. Father's Name (First, Middle, Last) Thomas J. Sullivan			18. Mother's Name (First, Middle Grace Hewitt		
55i 7	Mary	d 2 should alth and M 27 is mar r traumat	W	19a. Informant's Name/Relationship (Type, Print) Diane C. Preziosi-daugh	ter 4	b. Mailing Address (Street a	nd Number or Rural Route Numbre Avenue-Bal	er, City or Town, State, Z Ltimore, Ma	aryland
Re21051	Baltimore, Maryland 21215-0036	Page 1 and nent of Hes int: If item iny or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemete	of Disposition (Name of ery, crematory or other place Funeral Char	pel Julu 7, 2011	20c. Location - City of Forest H.	ill, Maryland
Q.	Balti	permit. Departn Importa any inju	()	21. Signature of Funeral Service Licensee	e and c	22. Name and Addres	s of Facility I Chapel and Crema: Ford Road-Pa	tion Services	21234
b .	~ F	Ph __ sician/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	he death. Do	not enter the mode of dying	g, such as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
h	in the second	Medical Examiner	j.	Sequentially list conditions, D.	rdin	in diffici	le colitis		10 days
<i>2</i>		cuted and transit	xamine	from the control of t	,			LEVAMINER .	
A	. 09.	cate be executed physician and s the burial-transi	edical Examiner	resulting in death) Last Due to (or as a d	consequence		CERTIFICATION APPROVED BY MA	DICAL Examin	
	. Box 687	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti	Fetal dea	th 3 Ectopic pregnanc		23d. Date of d Month	elivery Day Year
	ds, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but Acute Kidney Injury				tobacco use contribute	to the cause of death?
	Division of Vital Records,	The law re cate has be page 2 sho	Completed by				per	opsy prior to formed? death?	utopsy findings available completion of cause of
	Vital	ysician: is certifi director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 Hospital: 1 Inpatien	t 2 🗆 ER/O	26. Pla Outpatient 3 DOA Other	ace of Death <i>(Check only one)</i> er: 4 Nursing Home 5 Res	sidence 6 🗌 Other (Spe	ecify)
	on of	To the Hospital or Attending Physician: The la within 24 hours are death. To the Funeral Director After this certificate he completed filled by the funeral director, page	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		Time of 28c. Injury work M 1	at 28d. Describe ? Yes 2 \sum No	how injury occurred	
	Divis	talor Att rsaerd al Direct ediby t		4 Homicide determined 28e. Place of Injury building, etc. (arm, street, factory, office		(Street and Number or R wn, State)	tural Route Number,
		the Hospi nin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check conly one) 1.★Certifying Physician: To the best of my dedical Examiner: On the basis of examiner: On the basis of examiner: To the best of my dedical Examiner: To the basis of examiner: To the basis of	mination and/	or investigation, in my opinio	n, death occurred at the time, date	and place, and due to the	e cause(s) and manner stated.
		0		29b. Signature and title of certifier	, D.	O · RE	5 000	July 5,	ath, Day, Year)
		Stat Registra		30. Name and address of person who completed cause of dea Javaid M. Khay, 20. 5. v. 31. Date filed (Month, Day, Year) 32. Registrar's JUL 0 8 2011			timare, 2401 w	· Belveder Ave	2, Bulhinare, MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1.	For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth and Death		gie 2 0	24708
Physician	1	Decedent's Name (First, Mid Geor		rson				2. Date of De Month	Day Y	3. Time of Death 8:35 A M
/Medica Examine		. Facility Name (If not institute Manor Care	ion, give street and num			4b. City, Town, or Towson			4c. County of	Death :imore
Funeral Director	5.	Social Security Number 220–34–3783		7. Age (In <i>yrs. Ia</i> 73	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da	th ly, Year) 20, 1938	Birthplace (State or Foreign Country) UTIK
aryland show	10	sual Residence of Decedent Da. State 10b. Coun	ity	1	, Town or Loc					10d. Inside City Limits 1X Yes 2 □ No
ulter death with the Mar ritems 23a or 28a-fsi niner must be notified	10	MD De. Street and Number 100 Bolton A	Apt 503	Di	altimo	10f. Zip Code 21201			10g. Citizen of What Country? USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	2	Narital Status Never Married 2	12. Was Dece Armed For arried 1 (1) Yes If Yes Giv	2 □ No e		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		Specify Yes or No to Rican, etc.)	Black,	American Indian, White, etc. white
Maryland 21215-0036 d 2 should be filed within 72 hours alt th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exert TO Re Completed by	nanaldilloo	15. Deced (Specify only high Elementary/Secondary (0-12 unk	ent's Education nest grade completed)) College (1-		16a. Deced (Give life. L	ent's Usual Occupi kind of work done of OO NOT use retired	ation unk during most of wo	prking	16b. Kind of Busin	ness/Industry unk
yland Z	מ 17	7. Father's Name (First, Middl	e, Last) unk	'			18. Mother's Na	me (First, Middle	, Maiden Sumame)	unk
Mary nd 2 shou alth and M 27 is mar r traumat		9a. Informant's Name/Relatio Alice Ike -							ner, City or Town, St more, MD	
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If item any injury or other		Da. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other	(Specify)in stat	State ce	emetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location - C	ty or Town, State
Balt permit. Departr imports any inji		1. Situative of Funeral Same Ronal d	UNIVI			655 W. B	altimore	St; Bal	tomy Board Ltimore, I	
Pnysician /Medical	tr	3a. Pant. Enter the disease, shock or heart failure. Learn mmediate Cause (Finat lisease or condition esulting in death)	a S V	aused the death ach line. 1 dder or as a consequ	n C	er the mode of dyin			ırrest,	Approximate Interval Between Onset and Death 30 Min
10ate be executed to physician and sthe burial-transit and solutions.	d C th	equentially list conditions, any, leading to immediate ause. Enter underlying ause (Disease or injury aut initiated events esulting in death) Last	C	or as a consequ						
death certifi death certifi e attending I	ש	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live bi	come of pregnar irth 2 Fetal ant at time of de own	death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	
		art tt. Other significant cond	itions contributing to de	eath but not resu	Ilting in the ur	nderlying cause giv	en in Part I.			ute to the cause of death?
# 6		Hyper	tension)				24a. Was auto perf 1 \(\text{Yes}	opsy pri ormed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital F /sicien: Th /sicien: Th /sicien: Th /sicien: Th		 Was case referred to medi examiner? 1 ☐ Yes 2 ☑ No 	Hospital:	npatient 2 🗆 E	ER/Outpatien	t 3 DOA Oth	- A	eath (Check only	one) idence 6 □Other	/Specify)
Division of Vita or Attending Physicien: after death. Director: After this certific in by the funeral director.	- 1	7. Manner of Death 1 X Natural 5 ☐ Pen	28a. Date o		28b. Time of tnjury	28c. Injur Wor	v at		how injury occurred	
Division c Division c tai or Attending P s after death. at Director: After t ed in by the funera		3 ☐ Suicide 6 ☐ Cou	ld not be mined 28e. Place building	of Injury - At hong, etc. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
		9a. Certifier 1 X Certification (Check only one)	ying Physician: To the al Examiner: On the ba and mann	asis of examinat	ion and/or inv	estigation, in my o	pinion, death occ	curred at the time	, date and place, ar	id due to the cause(s)
To th withir To th		9b. Signature and title of certi	fier			29c. Licens	e number	3	July	(Month, Day, Year)
	3	0. Name and address of person	who completed caus	e of death (Item	23a) (Type,	Print) +15 Be	llona	Lane -	Towson.	(Monih, Day, Year) 30, 2011 MD 21204
State Registra	-	1. Date filed (Month, Day, Ye. AUG 0	3 2011	egistrar's Signat	. pa	Med				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:00 AM Gary Pfannenstiel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CATONSVILLE SUMM 15 PARK BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 X M 2 □ F Hours Oct 15, 1951 Maryland Director 59 219-58-3504 Usual Residence of Decedent or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9125 Frederick Rd. 21228 USA 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction laborer unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Pfannenstiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Edmondson Ave Apt 3; Baltimore, MD 21228 Catherine Carroll - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 【 Other (Specify) in state 21. Signat ire of Fineral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA LUNG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown certificate has been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (CHIZOPHRENIA Records, 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No WA or Attending Physician; **Division of Vital** the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.1 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital within 24 hours a

To the Funeral C Medical 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING 00056948 JULY 2011

Registrar

State

4

S

ANNEN

T

Q

32. Rajistrar's Signature

AVE SUITE 204 BALTIMORE

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMES TAWSINDA 3455 WILKENS

TANSINDA

31. Date filed (Month, Ear. Year)

Division of Vital Records, P.O. Box 68760,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed	EX
within 24 hours arter beaut. To the Fundaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	amm

		Please Type or Print in Black In State of Maryland / Department		lental Hygie	_	24710			
- · · ·		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death			
Physicia /Medic		Yvonne Quayle		Month July	20 2011	9:55 AM			
Examin	er	4a. Facility Name (If not institution, give street and number) 4831 Ft. Sumner Drive	4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgom				
Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 □ M 2 ☒ F 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 19,	(ear) Co.	nplace (State or Foreign untry) tah			
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lc	cation			10d. Inside City Limits			
Maryli a-f sho	tor	MD Montgomery Bethe	sda			1 □Yes 2 □No			
h with the 23a or 28a	Funeral Director	10e. Street and Number 4831 Ft. Summer Dr.	10f. Zip Code 20816	10g	g. Citizen of What Co USA	untry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ρ	1 Never Married 2 Married 1 Tyes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 🏿 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	, etc.			
nin 72 hor s. in "natur Medical I	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/	ndustry			
ed with ygiene ner tha t, live	Com	12 4 pr	operty manager	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	real est	ate			
t be file antal H ed oth		17. Father's Name (First, Middle, Last) Jesse Pomeroy Rich		e (First, Middle, Ma 2 Rogers	aiden Surname)				
d 2 should th and Me ?7 is mark traumatik	ပ	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Run 31 Ft. Sumner Dr;	ral Route Number, (City or Town, State, 2	Tip Code) 20816			
ages 1 an ent of Heal nt: If item 2 y or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)	osition (Name of matory or other place)	Date 20	Oc. Location - City or	Town, State			
permit. F Departm Importar any injur			2. Name and Address of Facility Sta 655 W. Baltimore			21201			
Physician		23a. Part Enter the disease, of complications that caused the death. Do not en shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death 2 YEARS			
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
icate be executed physician and s the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the I	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	ivery Day Year			
luires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the up and the significant conditions are significant conditions.	nderlying cause given in Part I.		acco use contribute to	o the cause of death?			
The law require cate has been sip page 2 should b	Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of			
Physiclan: The rthis certificate Ir ral director, page	Be C	25. Was case referred to medical examiner?		th (Check only one)	-				
Physi r this o	<u>۲</u>	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Residen	nce 6 Other (Spe	cify)			
ath. r: After e funera	ation	1'⊠ Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	f 28c. Injury at Work? M 1 □Yes 2 □No						
al or Atte s after des il Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.							
To the within common co	Σ	29b. Signature and the of certifier Ming Joeng M.	29c. License number D 5204	3	d. Date signed (Month $7/2 I/2$	h, Day, Year)			
		30. Name and address of person who completed cause of death (fem 23a) (Type Chun-Ming Tsem, M.D. 108/D 31. Date filed (Month, Day, Year) 32. Registrar's Signature	D 5204 Connecticut Ave	nue, Ken	sington_	MD 20895			
Sta Registr		AUC 0 2 2011 Julius B. Apa	uli)		ν				
	204	AUG U J LUI							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N			21.711
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	. N2011	24711
	Physicia		JAMES H QUARTNER		Month	Day Year 2011	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 2011 2	4c. County of Dear	4:54 P M
			3417 PHILIPS DRIVE	BALTIMORE		BALTI	
	Funeral		5. Social Security Number 6, Sex 7. Age (In yrs. last birthd:	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		212 20 0130	. Worth's Days Flodis Will.	07/13/1	932	PA PA
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	laryla 3a-f s iified	ect	MD BALTIMORE BALT	IMORE			1 ☐ Yes 2 X No
	or 2	₫	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
:	s 23a	Funeral Director	3417 PHILIPS DRIVE	21208		USA	
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	,
98	after Il", or xamil	d by	1 Never Married 2 A Married 1 Xyes 2 No	1 ☐ Yes 2X No Specify:	riiedii, etely	Black, White	
8	atura cal E	Completed	Teal of Dates.	cedent's Usual Occupation			HITE
215	n 721 an "n Medi	ш	(Specify only highest grade completed) (G	ve kind of work done during most of work . DO NOT use retired)	ing 16	b. Kind of Business	Industry
21	withing giene rear the		AST PRESIDENT		LAUNDRY		
nd [tal Hy tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Surname)	
<u> </u>	uld be I Men narke natic	-	MORRIS QUARTNER	MAMIE		S	HERMAN
∑ Za	12 should be file alth and Mental B 27 is marked o r traumatic eve		1	ailing Address (Street and Number or Rura			_
آ	and Heal tem 2			17 PHILIPS DRIVE, B		MD 2120 c. Location - City or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of	rematory or other place)		,	
iii ii	oartm sortal sortal / injur		21. Signature of Funeral Service Licensee	RE HEBREW CEM 08/0 22. Name and Address of Facility SO		REISTERS N & BROS.	
m	Deparation Deparation		Matt Cevinso-	8900 REISTERSTOWN			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between
- P	hysician/		Immediate Cause (Final disease or condition	FAILURE			Onset and Death
-	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. AESCLATORY Due to (or as a consequence of): Sequentially list conditions, If the body being a consequence of): Due to (or as a consequence of):				7
		er	Sequentially list conditions, If the large leading to him which the large leading the large leading to him which the large leading to him which the large leading the large leading to him which the large leading the large leading to him which the large leading the large leading the large leading to him which the large leading the large leading the large leading the large leading the large leading the large leading the large leading the large leading the large le	ENEUMONIA.			3 mos.
Pa-	nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	IL CALCINOMO - H	FAD/WE	2/	948AR
i Jox	sician and burial-transit	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):	<i>10 0171 0171 0010</i>	(), (12 "	, , , , , ,
. 68760 Certificate be executed	0 > 0	dical	d				
6876	ng ph	Mec	IF FEMALE:			1	
9 ×	attending ph	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death			23d. Date of de	*
P.O. Box	the a	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year
O. E	been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	ാ തറ് 🏻	d by		31	1 🗆 Yes	2 10 3 P	robably 4 🗆 Unknown
cords,	s beel	olete			24a. Was an		topsy findings available
Records,	certificate has t	Completed			autopsy performed 1 ☐ Yes 2 €	d? death?	completion of cause of
al	ortifica stor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		INO TE	2 🗆 110
Vital	this ce	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		me 5 Residenc	e 6 Other (Spec	ify)
ם ק	After 1 funera	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injur injur	/ work?	28d. Describe how i	njury occurred	
SIOIS	death ctor: y the	tific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide datemined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	20f Location (Ctros	t and Number or Ru	ml Pouto Number
No.	s after I Dire d in b		4 Homicide determined 256. Place of Injury - At nome, farm, building, etc. (Specify)	street, factory, office	City or Town, S		ar noute rumber,
Division of Ospital or Attending Ph	within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	edical	29a. Certifier Certifying Physician: To the best of my knowledge, dea	h occured at the time, date and place, an	d due to the cause(s	s) and manner as sta	ited.
P H	the Fu	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination and/or in only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at e, death occurred at the time, date and plac	the time, date and pee, and due to the cau	lace, and due to the duse(s) and manner as	cause(s) and manner stated. stated.
P	To		29b. Signatur and trill of certifier	29c. License number		Date signed (Month	, Day, Year)
			Mu Mellesser. am.	D-20465		8/1/201/	/ •
	0		30. Name and address of posson who completed cause of death (Item 23a) (Type DA - STORM GLASSON - 2)		E 30	21200	
	Stat	e	31. Date filed (Month, Day, Year) AUG 0 3 2011 August 32. Registrar's Structure	ov john a sofee	e wel.	2.200	
	Registra	ır	AUG U 3 ZUII Cleaner Va. 19 mas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 10:58 P™ Louis Edward Van Rossum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson Social Security Number Date or D. (Month, Day, Ye If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 □ F Days Hours Min. 92 1919 Maryland Director August 212**-**01-6234 Usual Residence of Decedent ural", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🗓 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21,220 United States 1320 Windlass Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify. "natural", white WWII Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other tha draftsman aerospace company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Rohleder Herbert Van Rossum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5214 Daybrook Cir., #347 21237 Baltimore, MD Dianne Van Rossum/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o Department of Important: If it any injury or o 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gard Aug. 2,2011 | Timonium, Maryland Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Vall 200 E. Padonia Rd. Timonium, MD 21093 P 200 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested experts.) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit 0 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed certificate 2 🗆 No 1 Yes within 24 hours after occur.

To the Funeral Director: After this certification of the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No Dice 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 2 🗌 No 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature

State Registrar

31. Date filed (Month, Day, Year,

AUG 0 3 2011

6701

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Emma Millie Reidler July 20°I1 12:10p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1433 Fairmount Carroll Hampstead 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 □ M 2 🔽 F Days Hours (Month, Day, Yea Country) 174-20-0874 **Director** 83 Jan. Ĩ928 Penn Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes XX No Carroll Hampstead 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 1433 Fairmount Road 21074 America Page 1 and 2 should be filed within 72 hours after death whent of Health and Mental Hydiene. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2XXNo Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th Seamstress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of John Harner Stella Carl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important If item 27 is any injury or other trau once. Minnie Evelyn Lucas (Daughter) 1433 Fairmount Rd., Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Fearnot Cemetery 4 Donation 5 Other (Specify) 8/2/11 Fearnot, PA 21. Signature of Funer Service Lig 22. Name and Address of FacilityEckhardt Funeral Chapel Wmau 3296 Charmil Dr. Manchester, MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death k, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ ancrea disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter oncernying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical that the d ath certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Vear ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2/1No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifies completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year, Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗡 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | | 3 | | (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

29b. Signature and title of certifie

ClmW

Pansuriy

3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2111

Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D0651705

Hanover Pike Hampstead

11-05735	
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narles E. Ryder	State	e of Maryland / D	epartmen	t of Healtl	h and Ment		2011	24714	
	1- For State Registrar		Certificate	of Death			eg. No.		
Physician/ Jedical Examine		•				2. Date of Deat Month July 31, 20	Day Year	3. Time of Death 1217 hrs	
die	4a. Facility Name (if not institution, g Stoney Creek	ive street and number)		4b. City, To Pasad	own, or Location o	of Death	4c. County of Deat Anne Arunde		
Funeral	100		yrs, last birthda				th(MM/DD/YYYY) 9. Bi Forei		
Director		X _M 2 F 48	8	Yrs. Months	Days Hours	Min. 3/21/		puntry) MD	
any	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or I	ocation				10d. Inside City Limits	
	MD Balti	more	На	lethorp	e			1 Yes 2 X No	
the Maryland s or 28s-f sh tified at one Director	10e. Street and Number			10f. Zip (Code	10	0g. Citizen of What Cοι	intry?	
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hours natur Exam	15. Decedent's Education (Specify	only highest grade complet			ccupation (Give Fing life, DO NOT		16b. Kind of Business	Industry	
5-0036 ed within 72 hour lygiene. the Medical Exan	Elementary/Secondary (0-12)	College (1-4 or 5+)	М	echanic			Heavy Eq	uipment	
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	Arhtur Leo Rider		1400	92		rginia A. H			
_ 0 0 5 5 1	19a. Informant's Name/Relationship Christopher M. R		7.0	-	•		nber, City or Town, State Maryland		
e, N 1 and 2 Health litem 2	20a. Method of Disposition		20b. Place of D			Date	20c. Location - City or		
Baltimore, MD permit. Pages I and 2 sh Department of free that has Important: If free at the injury or other traumat	1 X Burial 2 Cremation 3 4 Donation 5 Other Specia		Loudon		metery	8/4/2011	Baltimore	, Maryland	
Salti ermit. Pepartm mports njury c	21 Signature of Funeral Service Lice			22. Name and A	ddress of Facility	Hubbard Fu	neral Home	, Inc.	
Physician	23a. Part I. Enter the disease, or con	nplications that caused the					more, Mary	Land 21229 Approximate Interval	
/Medical	failure. List only one cause on				, .			Between Onset and Death	
Examiner	or condition resulting in death) Due to (or as a consequence of):								
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executed an and al - transit	events resulting in death) Last	d.	ince or).						
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box 68760, the death certificate be the death certificate be by the attending physicicle for use as the burnched for use as th	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o		Fetal death	3 Ectopic	pregnancy	23d. Date of deliver	y Day Year	
ox 68 auth certification or use as sician	past 12 months?	past 12 months? 4 Pregnant at time of death 5 Other (Specify)							
D. Be t the der by the a ached fe	Part II. Other significant conditions	9 UNKNOWN	t not resulting in	the underlying o	cause given in Pa	rt I. 23e. Did to	bacco use contribute to	the cause of death?	
es tha signed be det						1 Yes	2 No 3 Pro	bably 4 🗸 Unknown	
of Vital Records, as Physician: The law requirements occuping the page 2 should meral director, page 2 should no. To Be Completed						24a. Was a autop		utopsy findings available completion of cause of	
Reco The law cate has page 2 s	24a. Was an autopsy performe 1 ✓ Yes 2							es 2 No	
tal Reciding: The certificate ecetor, page	25. Was case referred to medical examiner?	[Hospital: 4 Innetions			6.Place of Death (
of Virginia Physics of Vir	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury			Bc. Injury at Work		Residence 6 Other	er: Scene	
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Division or spital or Attending nours after death. neral Director: After filled in by the function: Certification:	2 X Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Injury	_	street, factory,	office building, etc	c. 28f. Location (S	Street and Number or R	ural Route Number, City	
Divisior Hospital or Attend 24 hours after death. Puneral Director: stely filled in by the jal Certificatic	4 Homicide determin		creek			Anne Ar	undel Count	y,MD	
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)									
To with To com	29b. Signature and title of certifier	and manner stated.	 	29c.	License number		29d. Date signed (Mo	onth, Day, Year)	
	Theodore VII	Kind TR.	un D	_	O.C.M.E.	OCME	August 1, 2011		
	30. Name and address of person who Theodore M. King, Jr., M			er 900 W F	Baltimore Str	eet, Baltimore, MD	21223		
State	31. Date filed (Month, Day, Year)	32. Registrar's S							
Registra		011 1	. 1	harled					

ORIGINAL

			. FOI	artment of Health and Mental	•
			rogota	ertificate of Death	Reg. No.
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Alvin Rosenbalm	1y 28 2011 8:49 AM	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
mar!			7835 E. Baltimore Street	Baltimore If Under 1 Year If Under 24 Hrs. 8 Date of	
	Funeral Director		5. Social Securify Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F 60 Yrs.	Months Days Hours Min. (Month	f Birth 9. Birthplace (State or Foreign Country) 5, 1950 Tennessee
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
	Mary a-f sh	ż	MD Baltim	ore	1 Aves 2 □ No
	with the	I Director	10e. Street and Number 7835 E. Baltimore St.	10f. Zip Code 21224	10g. Citizen of What Country? USA
	ms 2	Funeral	11 Monitol Status 12 Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	or No- 14. Race - American Indian,
980	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exxodrac must be redified at	þ	A med Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Hican, etc 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc. Specify: white
21215-0036	n 72 ho "natur edical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)	nechanic	automotive
Maryland 3	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Modical Examinational Legit of all	To Be C	17. Father's Name (First, Middle, Last) Albert Rosenbalm	18. Mother's Name (First, Mi Mary Rosent	
ary	and N		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
Σ.	and 2 ealth n 27 i			304 Hillcrest Ave; Parky	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) in state	position (Name of Date ematory or other place)	20c. Location - City or Town, State
Balt	permit. Departi Importi any inji		21. Signature of Prints Service Licensee Wage Irector	22. Name and Address of Facility State An 655 W. Baltimore St; B	atomy Board Saltimore, Maryland 21201
,09	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate be executed by the attending physician and are larged for use as the burial-transit The law requires that the death certificate be executed as the larged larg	cal Examiner	23a. Part \(\) Enter the disease or complications that caused the death. Do not e shock of heart failure. List only one caust on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	leratic Cardia	Onset and Death
O. Box 68		Physician/Medic		☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
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Vital	Physician: r this certific ral director, I	o Be	examinar? 1 res 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 □ DOA Other: 4 □ Nursing Home 5 □	Residence 6 □ Other (Specify)
	ding Phy h. After this funeral c	n: To	27. Manny of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Desc	cribe how injury occurred
Ö	ath. rr: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division	al or Attending s after death. I Director: Afte ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Locat City of	ion (Street and Number or Rural Route Number, or Town, State)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) 1 itying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.		
	To the vithing compare	Ř	29b. Signature and title of certifier Deput	29c. License number	29d. Date signed (Month, Day, Year) July 29, 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type	DeTrimble 15:11	Thatherville, Md 2109
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3 2011 32 Registrar's Signature 3. 4	and	

Aloin Rossinhal m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20a-c&22 Per FH G918 8/11/2011 JH

State of Maryland / Department of Health and Mental Hygien 2 0 | |

Certificate of Death

			1 - State Registrar	ate of Maryland / [Department of H Certificate of D	ealth and M Death		ien 20		24716
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day	Year	3. Time of Death
· É.	Medic Examin		4a. Facility Name (if not institution, give street	4b. City, Town, or		July	4c. Count	z 0 [/ y of Death	0608 M	
	Funeral		Harbor Hospi 5. Social Security Number 117 14 6. Sex	7. Age (In yrs. last birti	Ba/t.	mor e	8. Date of Birth		9 Rinthi	place (State or Foreign
-	Director		1 □ M :	N7 -	Yrs. Months Days	Hours Min.	Dec 14,			121and
	show dat	for	Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	or Location	<u> </u>			1	Od. Inside City Limits
	e Mary r 28a-f notifie	Director	MD 10e. Street and Number	Balt	imore					1 X Yes 2 No
	with th s 23a o ust be	Funeral	3814 W. Bay Ave. A	pt 1	10f. Zip Code 21225	i		10g. Citizen of USA	What Cour	ntry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 No Yes, Give ear or Dates.	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		ce - Americ ck, White, W	
15-0	72 hour n "natu Tedical	Completed	15. Decedent's Educatio (Specify only highest grade cor	npleted)	Decedent's Usual Occupa (Give kind of work done do	ition unk uring most of working	200	16b. Kind of E		dustry pe Culture
212	within rgiene. Ier thar t, the N			ollege (1-4 or 5+) ink	life. DO NOT use retired)			Societ	_	pe curcure
and	be filed ental Hy ked oth c event	To Be	17. Father's Name <i>(First, Middle, Last)</i> unl	C		18. Mother's Name	(First, Middle, N	faiden Surnam	e) unk	
Baltimore, Maryland 21215-0036	d 2 should alth and Me 1 27 is mar	3	19a. Informant's Name/Relationship (Type, Pri Gerry Rau — son	nt) 19b	. Mailing Address (Street a 3814 W. Bay	nd Number or Rura Ave Apt	Route Number,	City or Town,	State, Zip (Mary	Code) 1and 21225
imore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Remo 4 ☐ Donation 5 X Other (Specify) 11	val from State State Atlant:	f Disposition (Name of ry, crematory or other place ic Cremation	8/03/	2011	20c. Location	urnie	_MD
Balt	permit. Depart Import any inj once.		21. Sig atus of Figural Service Licensee Non 3 1 S Way	e Director	22. Name and Addres	s of Facility State ty Cremat	ton Apar	uneral	Tho	mas Allen P yland 21201
	Physician/ Medical Examiner	ner	Sequentially list conditions, b. —	Allythmia Due to (or as a consequence of	ot enter the mode of dying	, such as cardiac o	anover, respiratory arre	**************************************	76	Approximate Interval Between Onset and Death Yhors Zhays
260	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last d	Consestive Due to (or as a consequence of	Heart Faile	re				TPays
Division of Vital Records, P.O. Box 68	he death certifi y the attending ched for use a	Physician/M	in the past 12 months?	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ Unknown	3	1			ate of deliv onth	ery Day Year
ds, P.O	quires that the series of the signed by the details and be detailed.								co use contribute to the cause of death?	
Recor	: The law recate has be page 2 sho	Completed by					24a. Was ar autops perform 1 Yes	sy .		psy findings available mpletion of cause of 2 No
Vital	s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	al: 1 Inpatient 2 I ER/Ou	Otho	ce of Death (Check		unas 6 🗆 Ott	ar /Sacoit	4
ion of	eath. or: After thi the funeral o	Certificate: T		a. Date of injury 28b. T	ime of 28c. Injury	at 2	8d. Describe ho			,
ivis	al or Att s after d I Direct d in by	Cert	4 Homicide determined	e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	:	28f. Location (St City or Town		oer or Rura	Route Number,
	he Hospite in 24 hours he Funera ipleted fille	Medical	29a. Certifier (Check only one) 1						use(s) and manner stated.	
	Noth To t		29b. Signature and title of certifier		29c. License			9d. Date signe		
			30. Name and aedress of person who complete			-00I		July 2	1, 2	011
			Christopher Long			ver st,	Baltin	nore, 1	10 3	1552
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 3 2011	3 00 Z 3. Registrar's Signature	backer					

DHMH 17 Rev 7/2009

State

Registrar

2011

WALTER RAFALKO

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP

AUG 03

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Carol Allan, MD

32. Registrar's Signature

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, 9917, 07/29/2011 dib_ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July ^D2011 Paul M. Sachs 8 7:06 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Min 1 X M 2 1 F New York 567-40-5835 Director 77 Nov. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the M. dical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13030 River Road 20854 United States death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 hours after 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced Korea Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Law other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any Injury or other traumatice EEmil Sachs Pearl Caldor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Sachs/Wife 13030 River Road, Potomac, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 3, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium 2011 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee A. William Tu sprea M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial Bleeding disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events sician and bunal-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the bunal Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Coagulopathy Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.
The Funeral Director; After this certificate has be moleted filled in by the funeral director, page 2 so autopsv perform yeriormeg? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jayanti Patel, M.D.

JUL 2 9 2011

Tarel Jayanti

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arks

00 52586

1500 Forest Glen Road, Silver Spring, Maryland

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 24,720 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ 4:39 PM 2011 ampson Medical County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore Wads worth Way Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min. **Director** ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 ☐ No TIMORE 10g. Citizen of What Country? 10f. Zip Code Street and Numbe USA 3 ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black White, etc ģ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 27 is marked other than "natuler traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) JOWN ASSOC Be 17. Father's Name (First, Middle, Last) and Mental and son 19a. Informant's ame/Relationship (Type, permit. Page 1 and 2 s Department of Health Important: If item 2 any injury or other once. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State . Signature of Funeral Service Linensed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death potocellular Carcinoma Immediate Cause (Final Physician/ month disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown dependance Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an invavende autopsy has of 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) To the Funeral Director: After this certific completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ivision of 28c. Injury at 28d Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral I Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 Jacdonasa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud 21236 Suite 200 Bultimore mo Can

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 08 01 3:05 Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City, Town, or Location of Death 4c. County of Death Somaritan Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director Usual Residence of Decedent show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 28a-f 1 Yes 2 No timore 10e. Street and Number ò 10g. Citizen of What Country? 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?

1 Yes No
If Yes, Give
Year or Dates. 6 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) and Mental Hygiene. is marked other than Elementary Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည NKNOWN 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of - City or Town, State Burial 2 Cremation 3 Removal from State Burial 2 Defendation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown Month ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed funeral director, page 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Director: / Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud Baltimore 5201

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sajauskas JUL 2:30 101 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE n/a If Under 24 Hrs 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛣 F Months 7/3911/9915 Director 216-30-5464 95 Russia Usual Residence of Decedent 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 1501 Frederick Road 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural", Specify: Completed 3 ☐ Widowed 4 🔀 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) it of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Ms. Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Tavlor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juozas Buciulis Viktolija unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Victor Sajauskas / Son P.O. Box 9395, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 X Cremation 3 - Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 7/28/2011 Baltimore, Maryland Signatu e of Funeral Service Ligens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ ASPIRATION disease or condition Medical resulting in death) Examiner SPHAGI Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami igned by the attending physician and be detached for use as the burial-transit MBNTEA that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 4 ☐ Pregnant 9 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes ivision of Vital filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 161829

Registrar
DHMH 17 Rev 7/2009

State

900 S. CATON AVE BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oilla Sowalus		For State Control of Post Process Certificate of Death		_	2011	24723
Physician		egistrar 1. Decedent's Name (First, Middle,Last)	 	Reg. 2. Date of Death		3. Time of Death
ledical Examin		Donna Sowards		July 4, 2011	ay Year	1419 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, T	Town, or Location of Death		4c. County of Death	
	4	63 Willow Spring Road Dunds		T	Baltimore Cou	
Funeral Director		5. Social Security Number Unix 6. Sex 1 M 2 F 54 1 Jsual Residence of Decedent	er 1 Year If Under 24Hrs. B Days Hours Min.		Foreig	hplace (State or unk n intry)
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
. .	_	MD Baltimore Dundalk				1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Ulrector	10e. Street and Number 63 Willow Spring Rd. 2	Code 1222	10g. Citizen of What Country? USA		
death with or items 23 must be no	<u>ا تة</u>		ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
after	ᆰ	or Dates:	X No specify:		Specify: whi	
2 hours	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 16a. Decedent's Usual during most of wor	Occupation (Give kind of winking life. DO NOT use reting	vork doneunk 19	6b. Kind of Business/I	ndustry unk
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	5	17. Father's Name (First, Middle, Last) unk	18.Mother's Name	(First, Middle, Ma	iden Surname) unk	
2121 uld be fill Mental F. marked	8					
D 2.	2 [(Street and Number or F			
y, MD and 2 sho cen 27 is rraumati	-	O · C · M · E · 900 W · 1 20a. Method of Disposition 20b. Place of Disposition (Nar	Baltimore St	·	ore, Maryl	
Baltimore, MD 21 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		1 Burial 2 Cremation 3 Removal from State crematory or other place; 4 Donation 5 X Other Specify: in , State				, i
Salti rmit. epartu iporta	T		Address of Facility Sta	te Anato	my Board	
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of	. Baltimore			
Physician /Medical	1	fallure. List only one cause on each line.				Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Combined effects of Carise Due to (or as a consequence of):	oprodol and	Alprazol	am	Deali
	1	Sequentially list conditions, b.				
	<u>=</u>	if any, leading to immediate Due to (or as a consequence of):				
		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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0, be ex sician	Medical	✓ UNPENDED ☐ AMENDED 23a,27,28a-f,per me	,g918 8-4-11	sm		
8760 ificate ig phy s the t		IF FEMALE: 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregna	ancv	23d. Date of delivery Month	y Day Year
x 66 h certi	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Spe				,
Bo te deat the at	Š	1 Yes 2 No 9 Unknown 9 Unknown			<u> </u>	
ires that the signed by detach	D.	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	1	acco use contribute to	_
quires en sign				24a. Was an		topsy findings available
Cords law requi	Completed			autopsy perform	prior to o	completion of cause of
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ician:	Ď/	examiner? [Hospital: 4] Inserting 2 FD/0: to stirred 2 FD	26. Place of Death (Check		esidence 6 🗸 Othe	- Cana
n of Vi	유	les 5 NO	28c. Injury at Work?		w injury occurred SU	
Division of Vital Records, rat or Attending Physician: The law requirers after death. **I Director: After this certificate has been is led in by the funeral director, page 2 should be a present of the funeral director.	Certification:	Natural 5 Pending C1 7 0 11 C1 0 00	1 Yes 2 √ No	ingested Alprazol	Carisopro	dol and
r Atto	<u>2</u>	2 X Accident Investigation fd /-3-11 fd 2:09 pm 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f Location (Str	eet end Number or Ru	ral Route Number, City
Dital of ours ad ours ad ours ad ours ad	튏	4 Homicide determined (Specify) Residence		Dundalk,	Md.	Springs Rd.
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.				
8 48.4	§		c. License number		29d. Date signed (Mo	nth, Day, Year)
		U-10 L-	O.C.M.E.		July 5, 2011	
	İ	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Ba	ltimore Street, Baltir	more, MD 212	23	
Sta	ite	31. Dete filed (Month, Day, Year) 32. Redistrar's Signature				· · · · · · · · · · · · · · · · · · ·
Registr	ar	31. Dete filed (Month, Day, Year) AUG 0 3 2011 32. Redistrar's Signature August 4. Aparls			_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5510c Per PHY ANA BD G824/2011 JH and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20^{pay} 2011 July 1:45 Рм William J. Sacco 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Harford Monkton 2705 Houcks Mill Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 9, 1 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F Ĩ929 Pennsylvania 187-24-7989 82 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Harford 1 ☐ Yes 2 X No Monkton Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21111 2705 Houcks Mill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No 1951-1 ☐ Never Married 2 X Married white 1 □Yes 2X No If Yes, Give Year or Dates: Specify. 1953 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) research mathmetician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Gori William Virgil Sacco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2705 Houcks Mill Rd; Monkton, Maryland 21111 June Sacco - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final anc reat an cla 3 years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. le

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Direct

Funeral

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exposition and be notified at

Health a

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr.

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician the as use for detached

signed by the within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I

Division of Vital Records, P.O. Box 68760,

	-yun teasion	<u> </u>		1 □ Yes 2√	No 3□ Probably 4□ Unknow			
	Dinhetes			24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical	7/14/00/		26. Place of De	ath (Check only one)				
examiner? 1 ☐ Yes 2* No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DO	Home 5 Residence	me 5 Residence 6 Other (Specify)				
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	o. Time of 2 Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred			
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		farm, street, factory	, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)			
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exal	nysician: To the best of my knowled niner: On the basis of examination and manner stated.	lge, death occurred and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. I place, and due to the cause(s)			
29b. Signature and title of certifier	R 0-	290	. License number	29d. Dat	e signed (Month, Day, Year)			

State Registrar

DHMH 17 Rev 1/2001

address of p

31. Date filed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For		State of	f Maryla	nd / Dep	artment of	Health	n and M	∕lental Hy	gien	е		
			State Registrar				Ce	rtificate of	Death	7		Reg. N	000		21,725
	Dhaminin	.,	1. Decedent's Name	e (First, Middle, L	_ast)						2. Date of De			'ear	3. Time of Death
	Physicia Medic		Mary	Rosalee	n Shiple	ey					Augus) II	3:20 AM
	Examin	er	4a. Facility Name (if	k 1"		i /		4b. City, Town		49	9	4	c. County of	Death	
			Citizer			Hom			e de					101	
4	Funeral		5. Social Security Nu		. Sex 1 ☐ M 2 🖾 F		. last birthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. Min.	8. Date of Bir (Month, Da May	th y, Ye <i>ar</i>)	022	9. Birthp Co <i>unt</i>	lace (State or Foreign ry) n Carolina
	Director		216-16-26 Usual Residence of			88					May 12	7 1	923 <u>[</u>	ort	n Carolina
	and at	1 1	10a. State	10b. County		10c. C	City, Town or Lo	cation		-				1	0d. Inside City Limits
	laryla 3a-f s iified	Director	Maryland	Harfo	ord		Aberde	'n							1 ☐ Yes 2X No
	or 2	اة	10e. Street and Num		ru .		Z IDOL GO	10f. Zip Code	Э			10g. C	Citizen of Wh	at Coun	try?
	with 123a ust b	era	531 NIA:	ino Stor	ney Road				210	01			USA	4	
	tems er m	Funeral	11. Marital Status	mo-orei	12. Was Deced	dent Ever in L	J.S. 13.	Was Decedent o	f Hispanic (Origin? (Spe	ecify Yes or No-		14. Race -		
98	fter d , or i	5	1 Never Marri		Armed For d 1 ☐ Yes If Yes, Give	2 XX No		If Yes, specify Cu 1 □ Yes 2 XX			Hidan, etc.)			White, e	
8	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	3 Widowed		Year or Da			1 1es 2-1e-1	NO Speci	iry.			Specify:	Whi	te
7	72 ho r "nat edica	ed	(Spec	15. Decedent's cify only highest	s Education grade completed)		(Give	dent's Usual Occ kind of work don	e during m	ost of worki	ing	16b.	Kind of Busi	ness Ind	lustry
12	within 7 giene. ner than t, the M	Š	Elementary/Seco	onday (0-12)	College (1-	4 or 5+)		O NOT use retire	,				G G		ilian E
d 2	ed wi Hygie Sther	as l	11 17. Father's Name (F	First Middle, Las	t)		1 5	<u>ecretar</u>	_	ther's Name	e (First, Middle,		S. GOV	ern	ient
Maryland 21215-0036	be filed ental Hyg ked oth ic event	힏		Poole	-4					Verna			-		
<u> </u>	should and Me is marl raumati		19a. Informant's Na		(Type, Print)		10h Maili	ng Address (Stre						a Zin C	oda)
	I2sh Ifhar 27is rtrau	ĺ	Lisa A.		, , ,)	1	Aldino-				-			
<u>5</u>	1 and of Heal item; other		20a. Method of Disp				Place of Dispo	sition (Name of			Date		Location - C		
ê E	Page ant: If ant or ury or			☐ Cremation 3 5 ☐ Other (Spe	Removal from :	State Re		natory`or other p emorial		ns 8/	4/2011	Be:	l Air.	Mai	ryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In contrastit if them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur		n	120									Home, P.A.
m	Pe a m e	- 1	PLUR	yery	now	all	1011 1	berdeen	, Mar	yland	21001	irgo	runer	aı ı	none, P.A.
	,		23a. Part 1. Enter the	he disease, or co	omplications that cay	aused the dea	ath. Do not ent	er the mode of d	ying, such	as cardiac o	or respiratory a	rrest,			Approximate Interval Between
P	h, sician/		Immediate Cause (I	Final	,			MI	Holin	rhK	5				Onset and Death
	Medical Examiner		resulting in death)	4	Due to (c	or as a conse	quence of):	166.	1 00-10					_	_
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	t t	nin	if any, leading to im cause. Enter Under	rlying	Due to (d	or as a conse	quence ot):							1	
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	oe ex ician burial	<u>8</u>	rooding ar dodary E	Luot			7								
760	phys the	edical			d										
89	ding seath	₹	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outo	come of pregr	nancy	_				Щ	23d. Date	of delive	erv.
XO.	atter affor u	icia	in the past 12 r	months?	4 🗌 Pregr	nant at time of		Ectopic pregna Other (specify)				- "	Month		Day Year
P.O. Box 687	Physician: The law requires that the death certific this certificate has been signed by the attending trail director, page 2 should be detached for use as	by Physician/M	1 Yes 21 9 Unknown	2110	9 Unkn	own									
P.C	that ned b	S S	Part II. Other signifi	icant conditions	s contributing to de	eath but not re	esulting in the	ınderlying cause	given in Pa	art I.	23e. Did t	obacco	use contribu	ute to th	e cause of death?
S, s	lures en sig uld b										1 🗆	Yes 2	2 □ No 3	☐ Prob	pably 4 Unknown
Sor	w rec Is beć 2 sho	blet									24a. Was auto				osy findings available inpletion of cause of
Mary R. Vital Records,	ate ha	Completed									perfe	ormed?	dea	ath?	2 No
	rtifica	Bec	25. Was case referre examiner?	ed to medical				26.	Place of D	eath (Check			101		
	nysic nis ce	은	1 ☐ Yes 2 🔀	Z No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	other:	Nursing Ho	me 5 🗆 Resi	dence	6 Other (Specify)	
	fter that Indeed		 Manner of Death Matural 	n 5 ☐ Pending	28a. Date o	of injury h, Day, Year)	28b. Time o injury		jury at ork?	- :	28d. Describe l	how inju	ry occurred		
2) j	Attending r death. ctor: After by the fune	iţi	2 Accident 3 Suicide	Investiga 6 Could no	the				☐ Yes 2						
	or At after (Direc in by	Certificate:	4 Homicide	determin	ed 28e. Place buildin	of Injury - At I ig, etc. (Spec	nome, tarm, sti <i>ify)</i>	eet, factory, offic	e		28f. Location (City or To			or Rural	Route Number,
-	prital ours eral l		29a. Certifier 1	X Certifying P	hysician: To the be	est of my kno	wledge death	occured at the tir	me date ar	nd place, an	d due to the ca	3115e(s) s	and manner:	as state	1
ति	the Hospital or hin 24 hours afte the Funeral Dirumpleted filled in I	Medical	(Check	Medical Exa	miner: On the basi urse Practioner: T	s of examinati	ion and/or inves	tigation, in my op	inion, death	occurred at	the time, date a	and plac	ce, and due to	the cau	ise(s) and manner stated.
	to the Hospital or Attendating Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		29b. Signature and t		1			29c. Lice		110	2		ate signed (I		
				Mari	es H	Men	Ala.		42	800	7	,	8/21	11	
			30. Name and addre	ess of person wh	o completed cause	e of death (Ite	em 23a) Type, i	Print) /1.	/	11 111	A dil	1	11	11	
le_			THOWA	94.	MICHUO	25	1 cen	5 Up.	411	4000	, my	/_	X10+	8	
	Stat Registra	•	31. Date filed (Month	JG 0 3 20	82. Re	egistrar's Sign	fure fac	Kel	/	/					
	- riegistiz	1	7.0	2 2 2 20	1	,	<u> </u>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Annette Turner

24726 State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Cathy an Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b_City, Town, or Location of Death 4c. County of Death makuland Baltimore Greneral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 43 Director 216-98-7760 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Baltimore MD NA 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a (Funeral 1817 Appleton Street 21217 U.S.A. or items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 ▼ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be more...h and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Homemaker House ortant: If item 27 is marked other injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mardel Turner Betty Snad 19a. Informant's Name/Relationship (Type, Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Appleton Street, Baltimore, Md 21217 Page 1 and 2: Mardel and Betty Turner 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ŏ X□ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) per it. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) King Memorial Park 8/8/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West o Funeral Service Licens 4300 Wabash Ave, Baltimore, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death edate Cause (Final Physician/ man Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division of Vital Records, P.O. Box 68760 completed filled in by the funeral 24 hours after death Funeral Director: within 2 To the F

> State Registrar

DHMH 17 Rev 7/2009

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only one) 29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 2011

amelinase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 11:44 Tyler Lynn Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 3038 Tioga Parkway Baltimore Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 06/17/1953 1 M 2 7 F 213-50-9162 Yrs. Maryland **Director** 58 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 □ No Baltimore Maryland 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 3038 Tioga Parkway 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates. 'natural", or þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Social Worker Social Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental His marked of ပ Joseph Samuel Tyler Jr. Willie Denise Bailey permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Denise Tyler/Mother 3038 Tioga Parkway, Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08/06/2011 Maryland Nat'l Ceme. Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. Signature of Funeral Service Licensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ardionulminary disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending p for use as t IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Veal 4 Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ⊑ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N page after death.

Director: After this certificate I
I in by the funeral director, page 2 No Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 4 No Other: ER/Outpatient 3 DOA မ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check Certifying se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on Signatu 29d. Date signed (Month, Day, Year) 30. Name and add 200 E 33rd St #136 BACK MD 21218 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar		artment of Health and M tificate of Death		2°0	24728
		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic	al	Dwayne Underwood			June June	30 2011	5:10 A ^M
Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death Baltimore		4c. County of Death	1
		Ravenwood Nursing & 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	if Under 1 Year I If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign untry) UNK
Funeral Director		218-28-2012		Months Days Hours Min.	(Month, Day, Y larch 11,	1932 Cou	intry) ùnk
		Usual Residence of Decedent	1.0.00 7				10d. Inside City Limits
arylar show	_	10a. State 10b. County MD Washington	10c. City, Town or Lo				1 ☐ Yes 2 No
the M	ecto	10e. Street and Number	8	10f, Zip Code	100	g. Citizen of What Cou	untry?
with Ba or	Funeral Director	7 E. Washington St.		21740		USA	
death ms 23	era		s Decedent Ever in U.S. UN K13.	Vas Decedent of Hispanic Origin? (Spi f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
or Ite	Fu	1 Never Married 2 Married 1	lYes 2□No	r Yes, specify Cuban, Mexican, Puento	nican, etc.)		hite
ural',	d by	3 Widowed 4 Divorced Ye	ar or Dates:		1 44		unk
n 72 h	lete	15. Decedent's Education (Specify only highest grade comp	leted) (Give	tent's Usual Occupation UTTK kind of work done during most of work DO NOT use retired)		6b. Kind of Business/l	ndustry
withii than	Completed	Elementary/Secondary (0-12) Co	lege (1-4or 5+) unk				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) unl		18. Mother's Name	e (First, Middle, Ma	aiden Sumame) un	ik
ny ic	은	19a. Informant's Name/Relationship (Type, Pri	nt) 19b. Mailin	ng Address (Street and Number or Run	al Route Number,	City or Town, State, Z	(ip Code)
od 2 s lith an 27 is r trau		Tom Jackson - nephe		955 Howard Dr; Hem			
s 1 ar f Hea item othe		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date 20	Oc. Location - City or	Town, State
Page nent of int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☑ Other (Specify) in	I from State				
permit. Departrimports Imports any inju		21. Sgnature of Funeral Service Licensee Ronald S Wade	All to other	Name and Address of Facility Sta >655 W. Baltimore			21201
		23a. Part. Enter the disease, or complications shock, sheart failure. List only one caus	s that caused the death. Do not enti-	er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician		I		Cancer			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c nsequence of):				
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
icate be executed physician and sthe burial-transit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
sician a	Ě	resulting in death) Last	Oue to (or as a consequence of):				
physi s the	dlcal	d					
certif nding use a	n/Me		es, outcome of pregnancy	Te		23d. Date of deli	ivery
death death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)		Month	Day Year
at the	Phys	9 Unknown		i Deal	220 Did tobo	acco use contribute to	the cause of death?
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contribution	ng to death but not resulting in the ui	nderlying cause given in Part I.)XYes		obably 4 Unknown
law requir as been si 2 should I	Completed				24a. Was an autopsy		itopsy findings available completion of cause of
vicion: The lav certificate has rector, page 2.	mo				perform	ed2 death?	2 □ No
sian: sartifica ctor, p	Be C	25. Was case referred to medical examiner?	- Arrest		h (Check only one)	
hysic his co	2	1 □ Yes No Hospita	1 Inpatient 2 ER/Outpatier	1 1	ome 5 \ Resider	nce 6 Other (Spec	cify)
ding F	tlon:	1 XNatural 5 ☐ Pending	. Date of Injury 28b. Time of (Month, Day Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe nov	williary occurred	
Attendation of the	fical	3 ☐ Suicide 6 ☐ Could not be 28e	. Place of Injury - At home, farm, str		28f. Location (Stre City or Town,	eet and Number or Ru	ural Route Number,
s after all Dire	Certification:	4 Homicide	building, etc. (Specify)		City of Town,	3(2(0)	
To the Hospital or Attending Physician: The Within 24 Hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: O	To the best of my knowledge, death in the basis of examination and/or in id manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	7	29c. License number	29	d. Date signed (Mont.	h, Day, Year)
		NILA	un w	043386		7-27-11	
		30. Name and address of person who complete	d cause of death (Item 23a) (Type,	Print)	- B-11	الكلا المحاسدة	21201
Sta	-	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Print) Eubew St 440	1 17417	arre, val	21201
Registr	ar	AUG 0 3 2011	Million L. China				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 24729 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 30°,2011 11:17P Duane John Weber 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 340 Grovethorn Road Middle River If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Juine 30,1963 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday, 1 X M 2 □ F 220-86-8006 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Maryland 1 Tes 2 V No Baltimore Middle River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 340 Grovethorn Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cable Technican Electronics 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Duane Wight Mabel Ann Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Grovethorn Road, Middle River, Maryland 21220 Sarah M. Weber 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland 4 Donation 5 Other (Specify) ArdentCremation, Inc. 8-4-11 Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical Examiner

attending physician and for use as the burial-transit

been signed by the s should be detached

cate has by page 2 s certificate

After this

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

þ

Completed

Be

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or

Sequentially list conditions, if any, leading to humodate cause. Enter Underlying Cause (Disease or linjury	Due to (or se a conesqu	period of j					
that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
_ ~							
 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3 🗌 Ector	oic pregnancy r (specify)		23d. Date of d		Year
 Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyi	ng cause given in Part I.		acco use contribute t	to the cause of d	
				24a. Was an autopsy perform 1 \square Yes 2	prior to death?	utopsy findings a completion of c es 2 No	available cause of
25. Was case referred to medical			26. Place of Death (Ch.	eck only one)			
examiner? 1 Yes 2 No	ospital: 1 lnpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Resider	nce 6 Other (Spe	ecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how	v injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		tory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Numb	oer,
(Check 2 Medical Examine	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	n and/or investigation	, in my opinion, death occurred	d at the time, date and	place, and due to the	e cause(s) and ma	anner stated
29b. Signature and title of Certifier			29c. License number	29	d. Date signed (Mon	th, Day, Year)	

DHMH 17 Rev 7/2009

State Registrar 08

ate filed (Month, Day, Year) AUG 0 3 2011

Philade

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Z Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month)0 i Name (if not institution, give street and number **Examiner** City, Town, or Location of Death County of Death last birthday)
Yrs. 9. Birthplace (State or Foreig **Funeral** 8. Date of Birth Country) Director 1926 Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No MD Baltimore Windsor Mill 10e. Street and Number 'natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 791.3 Milbury Road 21244 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Specify: African-American Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Foster Parent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Hicks, Jr. Virginia Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 Woodrow B. Smith/Son 7913 Milbury Road Windsor Mill, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 DOther (Specify) 8/5/2011 Loudon Park Baltimore, Maryland 22. Name and Address of Facility lie Funeral P.A. of Balto. Co. Signature of Fluiers / ervice License any in 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a consequience To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signard by the attending the included Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ເNo Month Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Certificate: To Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 \square No Investigation 6 Could not be Accident 3 Suicide 4 Homicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0071045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Const Road, Rondallstown

DHMH 17 Rev 7/2009

State

Registrar

Jonathan

31. Date filed (Month, Day, Year)

AUG 0

Morthwest

32. Registrar's Signature

11-05715 Ralph West Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ralph West	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Pos No. 20 24								
Physician	n/	Registrar 1. Decedent's Name (First, Middle,Last)	ne or beam	Reg. No. 2. Date of Death Month Day	3. Time of Death				
Medical Examin	er	4a. Facility Name (if not institution, give street end number)	4b. City, Town, or Location of Deat	July 30, 2011	2238 hrs				
)		Maryland General Hospital	Baltimore						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Mir	-	9. Birthplace (State or Foreign				
	ŀ	212-44-6377 1 M 2 F 67 Usual Residence of Decedent	Yrs.	1041071 17	Country) MD				
ow any		10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 Yes 2 No				
Maryland 28a-f show d at once.	Director	10e. Street and Number	Finore 101. Zip Code	10g. Citize	n of What Country?				
ith the M 23a or 2 notified		1802 Mc Cullon Street	21217		USA				
ath with	uneral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		4. Race - American Indian, Black, White, etc.				
after de	ð.	3 Widowed 4 Divorced or Dates:	1 Yes 2 No specify:	S	pecify: Black				
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of luring most of working life, DO NOT use ref	work done 16b. Kin ired)	d of Business/Industry				
5-0036 led within 7 Hygiene. l other than	Completed	12+4	Mechanic	Bal	fimore City				
215-C e filed v tal Hygi ted oth nt, the	မ်ို့ မြ	17-Father's Name (First, Middle, Last)	18 Mother's Nam	e (First, Middle, Maiden St	rname)				
7 물월 월 5 1 년	2		Mailing Address (Street and Number pr	Rural Route Number, City					
and 2 sho and 2 sho fealth and tem 27 is traumati	-		Disposition (Name of cemetery,	Date 20c. Loc	cation - City or Town, State				
More, Pages I and tent of Healt int. If item		1 Burial 2 Cremation 3 Removal from State Cremate 4 Donation 5 Other Specify:	and National 8-	6-11 /10	ire/mD				
Baltimore, M permit. Pages I and 2 Department of Health Important: Iften 2 injury or other traun	Ì	21. Sunature of Funeral Service Licer spe	22. Name and storess of Arcilla	ene finer	ral Services				
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Chronic Obstri	enter the mode of dving, such as cardiac	or respiratory arrest, shock	, or heart Approximate Interval				
/Medical	1	Immediate Cause (Final disease a narcotic (Morphine)		sease compile	Between Onset and Death				
, orth		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	Jiner	if any, leading to immediate use to (or as a consequence of).							
ted Insit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			7				
be executed sician and unial - transit	ᇹ		- f,per me,g918 8-1/ - ME,g918 , 8/12/2011,WS	II sm					
30x 68760 death certificate be attending physic	o ⊩	IF FEMALE: 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregna	23d. [Date of delivery				
Box 61 c death cert the attending d for use a	Physician/Mc	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		July 1941				
ut the de lached f		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?				
cords, P.O. B law requires that the d has been signed by the 2 should be detached	ed DA				No 3 Probably 4 V Unknown				
cord	Completed		-	24a. Was an autopsy perform <u>ed</u> ?	24b. Were autopsy findings available prior to completion of cause of death?				
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	9	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 ✔ No	1 Yes 2 No				
Vita hysicia this cer	<u>"</u>	examiner? 1 ✓ Yes 2 No Hospital 1 Inpatient 2 ✓ ER/Ou	patient 3 DOA Other Nursin	ng Home 5 Residence	Nonemark 1				
on of adding Ph.		1 Natural 5 Dending (Month, Day, Year)	ime of Injury 28c. Injury at Work?	28d. Describe how injury Unknown	occurred				
Division tal or Attendii rs after death.	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, far	0:10 pm res 2 in No.		Number or Rural Route Number, City				
		4 Homicide determined (Specify) Residence			02 McCulloh Street				
To the Howithin 24 h		(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and vestigation, in my opinion, death occurred a	at the time, date and place,	and due to the cause(s)				
H % H 8	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		te signed (Month, Day, Year)				
(6)	-	30, Name and address of person who completed cause of death (Item 23a)	U.C.IVI.E.	Augus	st 2, 2011				
		Melissa Brassell, MD Assistant Medical Examiner	900 W. Baltimore Street, Baltimo	re, MD 21223					
Stat Registra	te ar	31. Date filed (Month, Day Year) AUG 0 3 2011 32. registrar's Signature	barle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items State of Maryland / Department of Health and Mental Hygiene 24a,27 per dr.,g918,08/03/2011dhb Red. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July Physician 2011 9:09 Keith A. Williamson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Hurlock 7240 Hynson Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 25, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 M 2 □ F 1959 Maryland 213-80-7287 51 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD Dorchester Hurlock Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7240 Hynson Rd. 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 1977 — If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married white 1 ☐Yes 2 X No þ 3 Widowed 4 Divorced Year or Dates 1983 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1andscaping tree trimmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Lida Cole Luther William Williamson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7240 Hynson Rd; Hurlock, MD 21643 Doris Williamson - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5mall Immediate Causa (Final **Physician** VECU disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dusito (or as a consequence of) Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

Bloomingda

215

death (Item 23a) (Type, Print)

Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Amend Item 25 per me, g918,08/02/i2/iblada bf Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Hech-20 U av Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Baltwore Hospita © Date of Birth (Month, Day, Year) 06/28/1935 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 M 2 □ F 76 PA Director 187-26-7159 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Wedical Examinating the Indiffed at 1 ☐ Yes 2 No **Funeral Director** Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 809 Tuder Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🕍 No Specify. Specify: Completed by 3 Widowed 4 Divorced White Year or Dates Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Eleanor O'Brien ဂ္ James Hecht 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21158 Department of Health Important: If item 27 any Injury or other troonce. Tuder Dr. Jean Hecht-wife 809 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Winfield, MD Carrol Crem 07/23/2011 4 Donation 5 ☐ Other (Specify) South 22. Name and Address of Facility Fletcher Funeral Home Main St. Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final pertovation **Physician** DISTAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): 68760. Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P. O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 1 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¹XYes Hospital: 2 1NO 1 Inpatient 2 ER/Outpatient 3 DOA After this of funeral direction Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d Wolfe 600 al 31. Date filed (Month, Day, 82. Registrar's Signature Year. State AUG 0 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, 20b, per FH, G918, 8/3/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Lucy E. Walker 10:35 AM 30 1011 Juu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month), Day, Year | June 25, N/A BALTIMORE AGNES HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

VA **Funeral** Year) 1 ☐ M 2 🖫 F 240-20-6589 91 1920 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Director 1 ☐ Yes 2 TNo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2452 Barnesley Place USA Funeral 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Completed by SpecifyBlack 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ite M. Elementary/Secondary (0-12) College (1-4or 5+) 8th N/A <u>Home Maker</u> Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson Jones Annie Terry ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Walker/Daughter 2452 Barnesley Pl. Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arbutus, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem Pk Cromartie F/S 21. Signature Funeral Service Licenses 22. Name and Address of Facility Beverly D. 2700 Edmondson Ave Balto., MD en 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** EMBOL BILLTERAL Pulmonapy 4 DAYS disease or condition resulting in death) -/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No 1 □Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Recolds, P.O. Box 68760,

Division of Vital

JACKER

HOSPITAL

Neura

ST. AGNES

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9010

SANGITA VERHA

31. Date filed (Month, Day, Year)

AUG 0 3 2011

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MD

BALTIMORE,

2011

			Please Type or Print in amend #20a G&22 Per J State Amend #5 per Inf G951 5	Black In Fil C918 730/14 Cer	delible Ink 8/11/201 TRE tificate of D	c. Ensure A lealth and M Death	II Copies A Iental Hygie	Are Legible ene . N.2011	24735
	Physicia	n/	1. Decedent's Name (First, Middle, Last) George Edward Watson				2. Date of Death	Day Year	3. Time of Death
	Medic Examin		4a, Faqiii V Name (if ng vinstitution, give street and number)	12/	45. City Town or	Location of Death	0	4c. County of Dea	
مجدر	Funeral Director		5. Social Security Number 6. Sex 7. Age lin yrs. 1 M 2 G F 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 1, 1	9. Bii	thplace (State or Foreign buntry, un K
		_	Usual Residence of Decedent	City, Town or Loc	eation				10d. Inside City Limits
	Marylar 28a-f s otified	irecto	MD Baltimore	Catons					1 🗆 Yes 2 🏪 No
;	with the	Funeral Director	10e. Street and Number 407 Waveland Rd.		10f. Zip Code 21228		109	g. Citizen of What C USA	ountry?
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the fleath 14 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🕅 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
15-0	72 hour n "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa kind of work done of O NOT use retired)	ation during most of worki	ing 16	6b. Kind of Business	Industry
1212	d within lygiene. ther tha nt, the I	Be Co	Elementary/Seconday (0-12) College (1-4 or 5+) 12 0	fed	deral sec	urity off			government
/land	d be file Vental H arked of	To B	17. Father's Name (First, Middle, Last) Thomas Oliver Watson	_			e (First, Middle, Mai a Isadora		
Maryland 21215-0036	d 2 shoult alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Mary Forest - daughter	19b. Mailin 407	g Address (Street a Wavelan	and Number or Rura d Rd; Cat	n Route Number, Ca consville	ity or Town, State, Z MD 2122	ip Code)
Baltimore,	Page 1 an nent of He ant: If iterr ury or othe		1 Denotice 5 Notice 1 Post 1 Post 2 At	lantic	natory or other place	e) ▼ 8/05/	2011 G1	oc. Location - City o	e.MD
Balti	permit. Page Department of Important: If any injury or once,		21. Signatur of Euneral Service Licensee Wands Tecto 23a. Part Enter the disease, or complications that caused the dea shock, 6 heart failure. List only one cause on each line.	r 3	1mp14c4e	y Cremati	of white	Timore, MI	as Allen P.A.
	h sician/ Medical Examiner		23a. Part Enter the disease, or complications that caused the decisions that caused the decision of the cause (Final disease or condition resulting in death) 23a. Part Enter the disease, or complications that caused the decision on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consecutive condition as a consecutive condition)	lerotic					Approximate Interval Between Onset and Death
	eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Cause (or as a consecutive cause in the consecutive cause) c. Due to (or as a consecutive cause) d.						
. Box 68760	9 e 8	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time or 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	гу		23d. Date of d Month	elivery Day Year
18, P.O	Attending Physician: The law requires that the de- death. ector: Affer this certificate has been signed by the. by the funeral director, page 2 should be detached	ed by Pł	Part II. Other significant conditions contributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.			to the cause of death?
Record	The law req ate has bee page 2 shor	Completed					24a. Was an autopsy perform	prior to ed? death?	
Ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1	ZER/Outpotion	Oth	er:		ce 6 Other (Spe	acifu)
₹ of .	ing Phy 1. After this uneral d	ate: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at </td <td>28d. Describe how</td> <td></td> <td></td>	28d. Describe how		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At building, etc. (Special Country of the Coun			Yes 2 No	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	B Hospit 24 hour B Funera leted fills	Medical	29a. Certifier 1 Certifying Physician: To the best of my kno (Check 2 Medical Examiner: On the basis of examinat only one) 3 Certifying Nurse Practioner: To the best of	tion and/or invest	tigation, in my opinio	on, death occurred a	t the time, date and	place, and due to the	e cause(s) and manner stated.
	Neithir Comp	2							
			30. Name and address of person who completed cause of death (ite	em 23a) (Type, F	Print) mes He	1stigze	BALTI	mare 1	8, Zcil
	Sta		31. Date filed (Month, Day, Year)	ature pav	de l				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Judy Faye Webb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Date of Dis. (Month, Pay, Year) 1943 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min Country) Virginia **Director** 68 July 214-42-6266 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Baltimore Hampstead 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be with 1 Funeral 21157 USA 292 Stoner Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? [→] Yes 2 X No 14 Race - American Indian 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ae filed with... خوا Hygiene. خو**r than "r** (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kathleen Elizabeth Courtney Athie Cole Bache permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4341 Ridge Rd; Mt. Airy, Maryland 21771 Lisa Reid - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 X Donation 5 Other (Specify) Director 22. Name and Address of FacilityState Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 Enter the disease, or complications that cause, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month the 9 Unknown ed by the signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b, Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death?

1 Yes 2 No has autopsy 24 hours after death.

Funeral Director: After this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by

Division of Vital Records,

State Registrar

within 2.

Medical

4 Homicide

29a. Certifie

(Check

only or 29b. Signati

determined

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 9:15 P M Williams 29 2011 Elsie Dorothy 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON If Under Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2X F Months Hours Min. 1 (Month Day Year) Marvland 83 215-24-2696 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Timonium Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21093 215 Belmont Forest Court, Unit 102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Deceuent 2. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) G. Hudak William Gerting Mary D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Williams Shrewsbury, PA 16855 Reagan Drive Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Oruid Ridge Cemetery 8-2-2011 Pikesville Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CARDIOGENIC SHOCK resulting in death) Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events

Ph_sician/ Medical Examiner

Physician/

Medical

10a. State

Examiner

Funeral

Director

at

ams 23a or 28a-f sh r must be notified a

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.

Baltimore, Maryland 21215-0036

Director

Funeral I

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Completed

Be

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Examine

Be Completed by Physician/Medical

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Medical Certificate:

only one) 29b. Signature and title of certifie

FARHAN MAJEED,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

7601

32 Registrar's Signature

with the Maryland

and burial-tran attending physician the use as signed by page 2 funeral director, 24 hours after deat Funeral Director: filled in by

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

resulting in death) Last	Due to (or as a consequence or).	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
25. Was case referred to medical	26. Place of Death (Check on	ly one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year) injury work? on M 1 □ Yes 2 □ No	. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine	28e Place of Injury - At home form street factory office	Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occured at the time, date and place, and duniner: On the basis of examination and/or investigation, in my opinion, death occurred at the	

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

OSLER DRIVE,

29c. License number

D 68861

TOWSON.

29d. Date signed (Month. Dav. Year)

MARYLAND 21204

DHMH 17 Rev 7/2009

State Registrar

within 24 ho

To the Fune

completed f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata Registrar Amend#19a, PerFF			epartment of l Certificate of			gien2 0 1 1	24738
· 3	-		1. Decedent's Name (First, Middle, Last)	IEGC/-22-11C				2. Date of Dea Month		3. Time of Death
	Physici /Medic	al	Nathaniel Abraham					July	9 2011 4c. County of Deat	11:45 A M
**	Examin	er	4a. Facility Name (If not institution, give so 3609 Dixon Street	reet and number)			or Location of Death Hills		Prince Ge	
	Funeral	A .	5. Social Security Number 6. Sex	7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		hplace (State or Foreign
200	Funeral Director			M 2□ F	52 Yr	s. Months Days	Hours Min.	12/19/		untry) SC
AL.	pc ,		Usual Residence of Decedent		too City Town	os Logation				10d. Inside City Limits
	show	2	10a. State 10b. County MD Prince Geo		10c. City, Town (Temple I					1⊠Yes 2□No
	the M	ecto	10e, Street and Number	-8-		10f. Zip Code			10g. Citizen of What Co	ountry?
	With With	Funeral Director	3609 Dixon Street			20748			United Stat	tes
	death ms 2;	era		2. Was Decedent Ev	ver in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then *natural', or items 23a or 28e-f show event. I're Medical Exartical ratios Le modified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		1 ☐ Yes 2 Ž No		riloan, oto.)	Specify:	Black
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. C	ecedent's Usual Occu Give kind of work done ife. DO NOT use retir	upation e during most of work	ang	16b. Kind of Business	/Industry
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+) 1	ife. DO NOT use retir Lectrician	ed)		Private	
72	Hygiel Hygiel Ather ti		17. Father's Name (First, Middle, Last)	1	E-	Lectrician	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
and	id be f lenta! h ked of	Be C	Lawrence Abraham,	Sr.			Julia Ma			
Maryland	s 1 and 2 should if Health and Men item 27 is marke other traumatic	ဌ	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. !	Mailing Address (Stree	et and Number or Rui	ral Route Numbe	er, City or Town, State,	Zip Code)
	and 2 :sealth ar		Debra Murray Abrah	nam	36	09 Dixon S	treet, Ter	mple Hil	lls, MD 207	48
Jre,	of Health item 27 I		20a. Method of Disposition		20b. Place of I cemetery,	Disposition (Name of crematory or other pi	lace)	Date	20c. Location - City or	Town, State
m	Page nent c int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Resurre	ction Ceme	tery 7-16	-2011	linton, Ma	
Baltimore,	permit. Pages 'Department of H Important: If ite eny injury or of		21. Signature of Funeral Service License	100	00981	22. Name and Add 5538 Marl	ress of Facility Poj .boro Pike	pe Funer , Forest	cal Homes,	P.A. 20746
		П	23a. Part1. Enter the disease, or complice shock, or heart failure. List only of	ations that caused t	he death. Do no	t enter the mode of dy	ying, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	Metastat	ic Canc	er unknown	primary v	with liv	/er	3 months
	/Medical		disease or condition resulting in death)	metastas	es consequence of					
П	Examiner		Sequentially list conditions, b							
	ש ש	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):				
	cate be executed physicien and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a	consequence of	١٠				
60,	be ex icien burial	E E		Due to (or as a	consequence of	,.				
68760,	physicate s the	dicai	_ d							
.O. Box (it the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 Live birth 2 4 Pregnant at to 9 Unknown	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)		-	23d. Date of de Month	elivery Day Year
٥.	de de		Part II. Other significant conditions con	tributing to death but	t not resulting in	the underlying cause of	given in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
rds	quires n sign	d by						10	Yes 2 XO XNo 3∏F	Probably 4 Dunknown
Records,		Completed						24a. Was	an 24b. Were a	sutopsy findings available completion of cause of
Re	The law cate has b page 2 sl	mo						auto perfo	ormed? death?	
Vital	10 11	0	25. Was case referred to medical				26. Place of Dea			
of V	lysic lis ce direc	ToB	examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 Inpatien	nt 2 ER/Out	Datient 3 DOA			idence 6 ☐Other (Sp	ecify)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	ury V		28d. Describe	how injury occurred	
sio	death. ctor: Al y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		4.5		Yes 2 No	29f Location /	Street and Number or F	Qural Boute Number
Division	I or Attending after death. Director: After I in by the fune	Certification:	4 Homicide determined	building, etc.	ry - At nome, tari . (Specify)	m, street, factory, offic	28		wn, State)	lurar riodio rearribor,
_	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edicai Ce	(Check only 2 Madical Examin	ner: On the basis of	examination and	death occurred at the or investigation, in m	time, date and place y opinion, death occu	l , and due to the irred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stat	ю.		anse number		29d. Date signed (Mor	nth, Day, Year)
	X X 8		16	7(1).	M	D00	70811		7/14/20	/1
.^	_		30. Name and address of person who do	propleted cause of the	ath (Item 23a)	Type, Print)			111100	'-
K	5		David J. Perry, M.	D. 110 Ir	ving St	reet, N.W.	, Washing	ton, DC	20010	
E STATE OF	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2 0 2011	32. Registra	ris Signature	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 11:31 A^M Josephine Rose Adamsky Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death St. Mary's 41474 Culpepper Way Leonardtown 8. Date of Birth (Month, Day, May 28 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) Funeral Year) 1<u>918</u> 1 □ M 2 □**X**F Months 153-10-4249 Director 93 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 41474 Culpepper Way 20650 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give ξ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Clothing Bridal Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Natale Elizabeth Magistrini Zanetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Esler / Daughter 41474 Culpepper Way Leonardtown, MD 20650 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/29/2011 Franklin Lakes, NJ Christ the King Cem 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, M0005222955 Hollywood RD., Leonardtown, MD 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the duath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician. Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗌 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License numbe

Registrar

State

Avani D.

31. Date filed (Month, Day, Year)

Lane Court, Leonardtown, MD

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22650 Cedar

Shah, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ CHRISTINE ALESSI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Leonardtown Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 🔀 F Months Days Hours Virginia 226-42-2745 75 Yrs. Director Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21585 Peabody Street 20650 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Representative Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary B. Booher Silas E. Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Xina Raley/Daughter 40795 Leeland Road, Mechanicsville, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 Department of mportant: If any injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 07/29/2011 Charlotte Hall. 21. Storally of Funeral Service Cense Brinsfield Funeral Home, P.A. Margaret H. Hicks M01631 2955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CANCER (LYMPHOMA) LETASTATIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed that initiated events physician ar s the burial-ti resulting in death) Last Due to (or as a consequence of): Medical Box 68760 as the b IF FEMALE: asr 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown ò 4 Pregnant a 5 Other (specify) Month Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 & PERIPHENAL VISCULAR TASENTE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No HYPERTENSION! HYPERCEAGULBLE STATE 2° TO CA; 24a, Was an page 2 certificate has autopsy performed ARTAMO RATAY OSEO PERASIS Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical examiner? 1 ☐ Yes 2 🌠 No of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural iniury work? 5 Pending Division s after death. 2 No 2 Accident 3 Suicide 4 Homicide Investigation in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a poleted filled Medical 29a. Certifier 1 監 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I the 29b. Signatura and title of certific

10d. Inside City Limits

White

20659

Day

29d. Date signed (Month, Day, Year)

Approximate Interval Between Onset and Death

1 X Yes 2 □ No

ame and address of person who completed cause of death (Item 23a) (Type, Print) 74075 THREE NOTAL MO, HAVY COOD, UD 20636 State Registrar

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		Physiciai Medic		RAYMOND	WILLIAM	ALCORN	_						Month		2 Yea) II	18	55 PM
	٠. ب	Examin		4a. Facility Name (if MEMC		e street and number) HOSPI7	AL				Location			4	c. County of D	B0		
		Funeral Director		5. Social Security No. 579 579 - 30 - 77		#T 14 0	e (In yrs. la 83	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 1 2 — 2 7 — 1	th 1 ^y 9 ^y 2 ³ 7	9. Wa:	Birthpl Counti S n 1	ace (State ngton	or Foreign
		at at	. I	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside	City Limits
		Maryla 28a-f s otified	Director	MD	TALBO)T	Т	CILGHM								\perp		es 2 XX No
		with the s 23a or 3 ust be n	Funeral D	10e. Street and Nun		N TOWN RD				2167				Ü	Ditizen of What	Count	try?	
	980	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	۾	11. Marital Status 1	ied 2 X Married 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	Ever in U.S No		Was Deced If Yes, spec 1 Yes	ify Cubar	n, Mexica	n, Puerto F	oify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:		tc.	
	21215-0036	in 72 hour e. nan "natu Medical	Completed	Elementary/Sec	15. Decedent's lecify only highest grounday (0-12)		5+)	(Give life. D	dent's Usua kind of wor O NOT use	k done d retired)	luring mos	st of workir	ng		Kind of Busine		lustry	
		be filed with ental Hygien ked other th ic event, the	0.1	12 17. Father's Name (i	First, Middle, Last)		-	COMME	RCIAL	AGE	18. Moth	ner's Name	(First, Middle,		L ESTA	16		
	Maryland	and 2 should be Health and Me tem 27 is mark tem tranmatic	-	19a. Informant's Na EVELYN A	ame/Relationship (19b. Maili	ng Address	(Street a	and Numb	er or Rural	Route Mamba	er, City g him CHN	or Town, State an MAN, MA	, Zip C	ode)	21671
	Baltimore,			20a. Method of Disp 1 👿 Burial 2	position	Removal from State		Place of Disponentery, cred	osition (Nan matory or o	ne of ther plac	e)		ate	20c.	Location - Cit	y or To		
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M	-	Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):	10. 93								DA	10
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¥	Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Fet at time of	al death 3	Ectopic Other (s)		cy				23d. Date o		ery Day	Year
	P.O.	s that the gned by se detacl	by Ph			contributing to death	but not res	sulting in the	underlying	cause giv	ven in Par	t I.			o use contribu			
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	Division of Vital Records,	Attending r death. ector: Afte by the fun	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 ☐ Pending Investigati 6 ☐ Could not determine	on be 28e. Place of Ir	ijury - At h	ome, farm, st	M reet, factor	1 🗆	Yes 2		28f. Location City or To	(Street	and Number o	r Rura.	I Route Nu	ımber,
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		o the Ho rithin 24 I o the Fu ompleted	Medical	(Check only one)	3 Certifying Nu	miner: On the basis of irse Practioner: To th	examination examin	on and/or inve ny knowledge,	death occu	rred at th	on, death ne time, da e number	occurred at te and plac	the time, date be, and due to t	the caus	ace, and due to se(s) and mann Date signed (A	er as st	tated.	
		H S F Ö		> K	Raurer	w MD	death //	m 00s\ /F:	Drin*\			644	<u> </u>		ILY IS		2011	
	G	+VA		30. Name and addi	ress of person who	completed cause of	219 Start's Signs	11 23a) (Type,	SHIN	JATI	en	ST	,EAS	NOT	J. MD		2160)
The		Sta Registr		o i. Date med (MOII	JUL 18	2011 32. Regist	ww.	A. A.	face	1								

DHMH 17 Rev 7/2009

Ammended #26,7/28/11, St. Mary's, d1b
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of D			ene eg. No 2 ()	11 21.71.2					
		1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death					
Physi Me	ıcıan/ edical	B Daidaia Ann Abeil				Month July	15, 20	911 3:40 a M					
Exar	miner			4b. City, Town, or		1	4c. County of Death						
Funci	vol.	23598 Bayside Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Leonar If Under 1 Year		8. Date of Birth		Mary's 9. Birthplace (State or Foreign					
Funei Direct	_	212-78-3468 1 M 2 x F	73 Yrs.	Months Days	Hours Min.	(Month, Day, 104/18/1	Year) 938	Country Maryland					
d ow	. I	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc										
aylan a-f sh	Director	Maryland St. Mary's	Leonardt				10d. Inside City Limits 1 ☐ Yes 2 🛣 No						
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LIVISION OF VITAI RECORDS, F.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		2 Fetal death 3	Ectopic pregnancy	/		23d. Date Mont	of delivery th Day Year					
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To the within To the compl	Σ	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the beginning to the beginning of	oca of the knowledge, d	29c. License		-		(Month, Day, Year)					
eme		30. Name and address of person who completed cause of de Gwally S. Chhabra MD	. 1		0	1216	5 M 7	20110					
	State	31. Date filed (Month, Day, Year) 32. Registrar		ee Notch	road	Calltorn	ca , 11/12	20619					
Regis		III 1 8 2011 1 2		backer									

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of Healt tificate of Deat	h and Mental Hy <i>h</i>	giene 2011 Reg. No.	21710
	Physici /Medi		1. Decedent's Name (First, Middle, La Dwight Edu	vard	Bo	llinger	2. Date of De Month	Day Year	3. Time of Death
9	Examin Funeral Director		4a. Facility Name (If not institution, git The Johns Hopkins F 5. Social Security Number 6. 202–36–8810	ve street and number)	(In yrs. last birthday) 63 Yrs.	Baltimore City If Under 1 Year If Under Months Days Hour	der 24 Hrs. 8. Date of Bir	Baltimore C th ay, Year) 9. Birth Cou Rh Ay, Year) 1947 Han	
	Maryland -f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County PA York		10c. City, Town or Lo				10d. Inside City Limits 1 Yes 2 No
215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number 4073 Echo Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	12. Was Decedent E: Armed Forces? 1	16a. Dece	10f. Zip-Code 17329 Was Decedent of Hispanic f Yes, specify Cuban, Mex □ Yes 2 X No Spector Specifies Usual Occupation kind of work done during to DO NOT use retired)			rican Indian, ,, etc. Whit e
Maryland 2121	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be Com	17. Father's Name (First, Middle, Last Allen Bollinger 19a. Informant's Name/Relationship	4		A	other's Name (First, Middle In lene Markle Imber or Rural Route Numb		lip Code)
Baltimore, Ma	Page nent c ant: If ury or		Kasi L. Buchanan 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec	Daugl XRemoval from State ify)	nter 23 Dal 20b. Place of Dispo St. Paul S Cemete	kota Drive, Han sition (Name of metor, or other place) DUDS Church erv	over, PA 17331 July 16, 2011	20c. Location - City or Hanover, PA	Town, State
	bermit. Pag Department Important I Important I any liury o once.	er	23a. Part 1. Enter the disease, or conshock, or he in failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Metaste Due to (or as a	the death. Do not ent	1 .1	l Home, Inc.	269 Frederi Hanover, PA	
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
P.O. Box	that the death certifice by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the line of the li	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
Records, P.	w requires that th been signed by i should be detac	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the υ	underlying cause given in	1 🗆		obably 4 🗌 Unknown
		e Completed	25. Was case referred to medical			26. P	24a. Was auto perfu 1 Tyes	prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
Division of Vital	ding Phys h. After this funeral d	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death	be 28e Place of injur	Year) 28b. Time o Injury	f 28c. Injury at Work? M 1 □ Yes 2	2 ☐ No 28f. Location	idence 6 Other (Special Notice of Special Notice of Street and Number or R with State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	(check only 2 Medical Exa		examination and/or in		e and place, and due to the death occurred at the time	e, date and place, and du	e to the cause(s)
	WJL	Ž	29b. Signature and title of certifier Michael R.		- 1 di - 22 : -	29c. License numb		29d. Date signed (Mont	h, Day, Year)
	Sta Regist		30. Name and address of person when Michael R. G. 31. Date filed (Month, Day, Year) JUL 18	o completed cause of de 2000 a			600 North W	olfe St, Baltime	ore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 11.2011 BABINGTON 12:45P M PAUL LLOYD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1**火** M 2 □ F 047/13/1933 Director 220-28-7964 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Carroll Union Bridge 10g. Citizen of What Country? 10e. Street and Number Funeral 21791 USA 1024 McKinstrys Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced White Year or Dates ntal Hygiene. ed other than "natura : event, the Menical E: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Paving Company Owner Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Regina Flook Lloyd E. Babington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21791 1024 McKinstrys Mill Rd. Union Bridge, MD Betty Lou Babington-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State South Carroll Crem 7-12-11 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service hicensee 22. Name and Address of Facility Fletcher Funeral Home homes <u> 254 E. Main St.,Westminster,MD 21157</u> 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBABL STROKE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RO SCLERO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE RENAL DISEASE CORONARY Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 🔀 No DIABETES Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Na Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Go tilifying Nurse Practice on To the basis of my knowledge. Beath or number of the time. Base and place, and Suc to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number WIL 058808 071 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Florin Frederick, MD 21701 Rusu 400 w 7th St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death	Mental Hygiene	24745		
-			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
	Physician/				Month Day Year July 25, 2011	1:45 A ^M		
	Medio Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death				
	,		St. Mary's Hospital	Leonardtown	St. Mar	y's		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		irthplace (State or Foreign ountry)		
	Director		21/-60-5553		(Month, Day, Year) 02/24/1952 M	laryland		
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation		10d. Inside City Limits		
	laryla 3a-f s ified	ect	Maryland St. Mary's Mechani	csville		1 ☐ Yes 2 🗶 No		
	or 28	اقا	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?		
	with s 23a lust b	Funeral Director	27312 Three Notch Rd.	20659	United	States		
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - Am Black, Wh			
36	after (", or camir	i by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No 3 ☐ Widowed 4 🕅 Divorced Yes Give	1 ☐ Yes 2 X No Specify:	Specify: Wh			
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	4	Date 20c. Location - City o			
Ξij	it. Partmer rtmer rtant njury		4 Donation 5 Other (Specify) Brinsfiel	d-Echols Crem. 07/	26/2011 Charlotte insfield-Echols F.			
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		Н	Y WAS TO SEE THE SEE T			Approximate		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition) ESPIRATOR FAILUR On the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying arrest, and the mode of dying arre								
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	ate be executed physician and the burial-transit	ia E	resulting in death) Last Due to (or as a consequence of):					
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σ.	ires that the de signed by the	by F	206, Did tobacco use contribute to the					
ds,	requires been sig should k	ted			1 Yes 2 No 3	Probably 4 🗷 Unknown		
50	law re has be ge 2 sh	aldu			autopsy prior to	autopsy findings available completion of cause of		
The state of the s					es 2 No			
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<u>_</u>	Phys this ral dir	2: To	1 Yes 2 No Hospital: 1 Inpatient 2 EF/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	ent 3 □ COA 4 □ Nursing I	dome 5 Residence 6 Other (Special Control of the Special Control of	ecify)		
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<u>.</u>	al or s afte		building, etc. (Specify)		City or Town, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve					
	the h hin 24 the F mplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge	death occurred at the time, date and pl	ace, and due to the cause(s) and manner	as stated.		
	5 vit 5 co		29b. Signature and title of certifier	29c. License number	29d, Date signed (Mor			
	1		30. Warneland address of person who completed cause of death (Item 23a) (Type,	Drint)	10420			
سوم			30. Marnefand address of person who completed caute of death (Item 23a) (Type, PATRICIA GURW, MD ST, MI	DZ6344 Print) & HOSPITAL	. LEONARD TOWN	, MARYLAND		
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			For State	State of	Marylanc	•	artment of I		Mental Hy	giene Reg. N.2	חוו	24746	5
		_	Registrar 1. Decedent's Name (First, Middle, Last)			ertificate of Death				011	3. Time of Death	-	
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	Medic Examin		4a. Facility Name (if not institution,	give street and numb	per)		4b. City, Town, c	r Location of Dear		1	unty of Deat		
			24710 Budds 0	Creek Road			C1e	ements			St. Ma	ary's	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	6. Sex 7	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year)	9. Birt Co	thplace (State or Foreig	ın
	Director		220-12-3423 Usual Residence of Decedent		85	Yrs.			09/06	/1925_		Maryland	
	and show lat	Funeral Director	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	s
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	n the a or 2	al Di	10e. Street and Number				10f. Zip Code			J	of What Co	ountry?	_
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ဗ္ဗ	s afte ral", o Exan	q pe	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	☐ Yes 2 🛣 No	Specify:		Spe	ecify:	White	
2-0	hour hatu dical	Completed		nt's Education st grade completed)			lent's Usual Occup		arkina	16b. Kind	of Business	Industry	
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Maryland 21215-0036	Hygie Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, L	acti			Farmer		ame (First, Middle		icultu	ire	\dashv
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Baltimore,	permit. Page 1 and 2 should be file. Department of Health and Mental H Important: If Item 27 is marked of any injury or other traumatic ever		21. surflur of Funeral Service	Tore	lines) 22	Name and Addre	ess of Facility ey-Gardin 270. Leo	ner Fune onardtow	ral Ho	me. P 20650	.A.	
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20 X	endin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnand		Ectopic pregnan	cv		23d	I. Date of de	livery	
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7. E	signe d be d	d by	· · · · · · · · · · · · · · · · · ·					1 Yes 2 No 3 Probably 4 Unknown				vn	
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	leath.	ifica	2 Accident Investig	gation		. ,	M 1 □	Yes 2 □ No					
DIVISION	after o	Certificate:	4 Homicide determi	ined 28e. Place o	of Injury - At hom g, etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location City or To	Street and Nu wn, State)	ımber or Ru	ral Route Number,	
Hoenita L	to use reported or determine reported in the law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check . 2 Medical E	Physician: To the bes xaminer: On the basis	of examination a	and/or invest	igation, in my opini	on, death occurred	d at the time, date	and place, and	d due to the	cause(s) and manner sta	ated.
9	vithin of the omple	Σ	only one) 3 Certifying 295. Signature and title of certifier	Nurse Practioner: To	the best of my k	nowledge, o	leath occurred at the 29c. Licens		lace, and due to t	he cause(s) an 29d. Date si			
	->=0		·	/has	trus				15-		-28		
14		1	30. Name and address of person v	vho completed cause	of death (Item 2	3a) (Type, P			•	*	<u> </u>		
VP.			William D. Bo	oyd, M.D.	253	65 Po	int Look	out Rd.,	Leonard	town,	MD 20	650	
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 29	2011 32 eg	gistrar's Signatur	. 6	we						
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Please Type or Brint in Black Indelible 19/1 Figure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ 1, 59 AM BRAD FORD Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) Social Security Number **Funeral** 1 □ M 2 🖾 F Davs Hours Min. (Month, Day, Year) Maryland 216-48-5251 6.5Yrs. 1945 Director Sept. Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Salisbury Wicomico MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 623 Dover Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Yes, Give 2 K No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Mae Dryden Newland O'Grady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, MD 623 Dover Street (Husband) David P. Bradford Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Delmar, Delaware Crematory of Delmarva 7-16-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee 19940 Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dis ease 1 Yes 2 No 3 Probably 4 Unknown #240 *Dradtord* Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29c. License number 29b. Signature and title of certific D68576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTHWAY DR, BERLIN MD 21811 AGH 9733 NISAR SABEEHA MID 31. Date filed (Month, Day, Year) JUL 18 2011 Registrar

DHMH 17 Rev 7/2009

5/16/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24748 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jack Riggin Bennett 1227 July 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26050 Sharptown Line Road Wicomico Sharptown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 8, 1 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 🕱 M 2 🗆 F Months Hours Min Maryland Director 216-16-7359 Yrs 88 1923 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any portant or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Wicomico Sharptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26050 Sharptown Line Road 21861 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🗷 No Specify. If Yes, Give 3 Widowed 4 Divorced Specify. Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fred N. Bennett Mary Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce N. Bennett 32471 Mt. Pleasant Road Laurel, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Firemens Cemetery July 15, 2011 Sharptown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral
13 East Grove Home Street Delmar, DE Part 1. Enter the disease, or complication shock, or hear failure. List only one cause 23a. Part 1. Ente that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause Immediate Cause (Final Onset and Death Ph sician/ nent/a disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (buses or impury that introduce or impury that introduce or impury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available 24a, Was an page 2 s autopsy prior to completion of cause of death? certificate Yes 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 🔼 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Director: After this Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify) within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b 29d. Date signed (Month, Day, Year) 6 376 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

OSPICE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $J_{\mathbf{u}1\mathbf{v}}^{\mathsf{Month}}$ 2011 9:50 P^{M} Steven Russell Brown Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6722 Dion Road Federalsburg Caroline 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 30 Funeral 7. Age (In vrs. last birthday) 1**X** M 2 □ F Director 221-56-0286 Delaware 1960 Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No Caroline Federalsburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 6722 Dion Road 21632 "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc by 1 Never Married 2 Married ☐ Yes 2 ☐XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. I and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Building 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Marie Rash William Irvin Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 6722 Dion Road, Federalsburg, Maryland Linda M. Brown/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or July 19, 2011 Dover, Delaware Capitol Crematory 4 Donation, 5 Other (Specify) 21. Signal e of runeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. any relept 12 South Second Street, Denton, Maryland Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Ecque daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed and tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a d be detached f g 🗌 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ Completed cate has been signated bage 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 □ To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State

31. Date filed (Month

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 Day Physician/ SUMER EDUARDO CARRANZA COREMS 12 2011 1216 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BARTIMONE. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, 1 🔀 M 2 🗆 F El^{co}Salvador 213-65-7267 05 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22e congruent in the marked other than "natural", or items 22e congruent. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Anna Arundel Glenn Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral El Salvador 21061 6901 Glen Ridge Circle #C2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ Never Married 2 Married Salvadorian 1 Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kitchen Restaurant Prep Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Maria de la Paz Coreas Galileo Edmundo Carranza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Cousin) 218 Woodhill DR #C Glenn Burnie, MD. 21061 Milton Rene Chavez Aguirre 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 07/27/2011 cem@ennerpatopy or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dpto:Usulutan 4 ☐ Donation 5 ☐ Other (Specify) de Californ**i**a Santa Cruz Funeral Services, Inc 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 600 Kennedy ST, NW.Washington, DC. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx ate Interval Between Onset and Death complications Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ATION APPROVED BY MEDICAL THE Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 № No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) certific Be 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Natient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer injury 1 🔲 Natural 5 Pending ughtenine 2 🔀 No 1740 2 Accident 3 Suicide Investigation 12/11 bocation (Street and Tumber or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Pasadena. 9500 Fort Smallwood Kd fishing within 24 hours a To the Funeral I Medical Certifying Physician: To the best of not knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c, License number 07 19223 12 201 MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE

State Registrar ASHIKA

31. Date filed (Month, Day,

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2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 5 per F.D. 07721/2011 Carroll Co., will State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24751 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ 2011 11:35 AM James Milton Cole Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll 543 Poole Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 52Spgial Sapyrity Ny 1945 **Funeral** 1 XM 2 □ F Months Davs Hours 111/1371933 MD **Director** 216-30-5395 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Carroll Westminster ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 543 Poole Road items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1952—
If Yes, Give 14. Race - American Indian. 11. Marital Status "natural", or iter edical Examiner Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify Completed 3 Widowed 4 Divorced 1956 Year or Dates th and Mental Hygiene.
77 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter Baltimore Gas & Elect. 12 Be Filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. ဂ္ဂ Edward Cole Janie Elizabeth Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice Cole/wife 543 Poole Road, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. July 15,11 Finksburg, MD 21. Signature of Funeral Service 22. Name and Address of Facility Pritts Funeral Home & Chapel al 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death

2 months Immediate Cause (Final disease or condition Physician/ Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and tran Due to (or as a consequence of) the burial attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k Completed by Records, 1 Yes 2 No 3 Probably 4X Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Hospital or Attending Physician: The 1 Yes 2 No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2**X** No Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MJL 7/13/2011 D0064597 POTIVA who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person .23 Crossmads Dr Ste 340 Owings Mills MD 21117 MD PHD 31. Date filed (Month, Day, Year) 32. Registrar's Signature **JUL 14** parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #10c, 10e per FH, FCHD, Certificate of Death 7/19/11, LE Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Leona Irene Cherry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 092-24-2825 Days 1 □ M 2**X** F Hours $J_{\mathbf{u}}^{Month}2_{\mathbf{y}}^{gy}, \Upsilon_{\mathbf{1}}^{gas}$ 31 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director Pennsylnotified 28a-f Waynesboro Adams Waynsboro vanīa 10e. Street and Number 10655 10f. Zip Code r items 23a or ner must be r 5 10g. Citizen of What Country? Bailey Springs Lane Funeral 19655 Bailey Springs Lane 17268 United States Trlr. 45, filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Leon Cherry Dorothy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 10612 Victorian Ave., New Market, MD 21774 Terrence Jolliff / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 17, 2011 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 M Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland Signature of Fonoral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Physician/ Medical xaminerٹ sician and burial-transit attending physician for use as the buria Box 68760

page 2 s

the Hospital or Attending Physician: 'hin 24 hours after death. the Funeral Director. After this certificampleted filled in by the funeral director, I

Division of Vital Records, P.O.

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	23a. Fart 1. Enter lie disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List inly one cause on each line. Immediate use (Final disease or condition Preserved.)							
	resulting in death)	Due to (or as a consequence of):						
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b						
al Exan	Cause (Disease or linjury that initiated events resulting in death) Last	C						
ಠ		i						
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							
ted by PI	Part II. Other significant conditions con	23e. Did tobacco use contribute to	ntribute to the cause of death? 3 Probably 4 Unknown					
Comple		autopsy prior to performed? death?						
Be	25. Was case referred to medical examiner?	eck only one)						
0	1 ☐ Yes 2 No	Hospital: 1 No Other: 4 Nursing Home 5 Residence 6 Other						
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b. Time of injury at work? Month, Day, Year 28b. Time of injury 28c. Injury at work? 1	28d. Describe how injury occurred					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ural Route Number,					
edical	(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, date and place, er: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as st d at the time, date and place, and due to the	ated. cause(s) and manner state				

29c. License number

MDD71068

Jest 7th Street Frederick MD 21701

20**1**

Frederick

Black, White, etc.

White

New York

9:55

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🛣 No

Рм

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2011

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2011 July 13, **Physician** 1805 p ^M Paul Franklin Collins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Delmar 715 E Chestnut Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 13,1918 7. Age (In yrs. last birthday) 92 vrs If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Hours Months Days 1 MM 2□ F 222-01-9135 Delaware Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Westean Every near the restliked at 1 XYes 2 □ No Delmar Wicomico Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21875 715 E. Chestnut Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TXYes 2 No 194
If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. White Specify: δ 3 X Widowed 4 ☐ Divorced 1946 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chicken hatchery owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othany injury or other traumatic event Be Mary Francis Jackson William K. Collins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Salisbury, MD 31151 Stevens Lane (Daughter) June Brittingham 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Rurial 2 ☐ Cremation 3 ☐ Removal from State Belvidere Cemetery July 18, 2011 Belvidere, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee Short Funeral Home 13 E Grove St, Delmar, DE 19940 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or colonications shock, or heart-failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Physician ongestive /Medical Due to (or as a sequence of): Examiner Coronary Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque te of): Examine death certificate be executed tran and Due to (or as a consequence of): burial-t P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Tectopic pregnancy Month Year for in the past 12 months? 5 Other (specify) the 8 detached ☐Yes 2☐No 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 2 □No 1 ☐Yes 2 No 1 □ Yes ospital or Attending Physiclan: Thours after death.

Lours after death.

Lours Director: After this certificat it filled in by the funeral director, px Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ဂ္ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide e Hospital on 24 hours af e Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 D41721 MD UTC 30. Name and addr *s of person who completed cause of death (Item 23a) (Type, Print) IVA SALISBURY MD PAVLOS EPHAN E. SISTRE DR. 31. Date filed (Month, Day, Year) State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** orence COUDER 2:05 AM 201 15 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number)
DEET'S HEAD HOSP, Tal CE 4c. Gounty of Death Examiner Center Salisbul comico If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 F 212-56-1877 92 Director 06/14/1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Marilcol Examination to context any ones. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 TXNo Director Maryland Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21874 USA 6860 Bent Pine Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 XNo Specify White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator Convenience Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl John Alexander Lavinia Charlotte Bailey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6860 Bent Pine Rd., Willards, MD 21874 Candace Laws/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/2011 Coopers Cemetery Willards, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License, Policy and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death se Renal Immediate Cause (Final **Physician** mono disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069754 201 cause of death, (Nem 23a) (Type, Print), fer's Head Hospita 30. Name and address of person who comple Salisbury homas F. Kell 31. Date filed (Month, Day, strar's Signature State 18

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ 0105A M Sue 2011 ane Conklin Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SALISBULL KIEVMICO edicaz If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year Social Security Numbe Funeral 1 - M 2 XF Months Days Hours Min (Month, Day, Year) Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director be notified 1 ★ Yes 2 No ccomac hincoteaque 5 10e. Street and Numbe 10f. Zo Code 10g. Citizen of What Country? 23a Funeral must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Bace - American Indian. 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State lemperanceville, VA ☐ Donation 5 ☐ Other (Specify) Cometery 120/11 Taylor 21. Signature of Funeral Service Licensee Chincoleague, VA 22 Name and Address of Facility amanda Funcial Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hortic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) sician and burial-transit Obstructive Sleep that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ò Year Day Pregnant at time of death n signed by the and to be detached for 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes Yes Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita 2 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural injury 5 Pending work?
1 Yes 2 No Investigation Accident Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi-29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene state Amend Items 25,27,28a-f per me 9917,729/2011 and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8;45P. Milton Sigmond Physician/ Dorfman JMTy 2. Day 2011 Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14400 Homecrest Road, #255 Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 8. Date of Birth 577-01-7438 1 🕅 M 2 🗆 F Hours Min. OM 4th, 5 ay 1 1919 91 Washington, DČ Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Silver Spring 1 🗆 Yes 2 🖺 No Maryland Montogmery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 14400 Homecrest Road, #255 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 X Yes 2 \sum No
If Yes, Give 1943-1946 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: 3 X Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (012) Il Hygiene. College (1-4 or 5+) other traumatic event, the Intelligence Operations Specialist Defense Intelligency Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Louis Dorfman Goldstein Hattie permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Dorfman -daughter 1436 Sunningdale Lane Ormond Beach, FL 32174 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1🎇 Burial 2 🗌 Cremation 3 🗌 Removal from State King David Memorial Gdns 7/6/2011 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Donald V. Bofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line SUBDURAL HEMORRHAGE Immediate Cause (Final Physician/ / Medical 3 Weeks disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and PPROVED 8 Due to (or as a consequence of): resulting in death) Last CERTIFICATION Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease 23e. Did tobacco use contribute to the cause of death? þ cate has been signated to page 2 should to Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 XNO 4 Nursing Home 5 X Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? injury Probable fall. June,2011 **Unknown**^M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14400 Homecrest RD. Silver Spring, MD 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man D24543 July 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Rossi, M.D. 3305 N. Leisure World Blvd. Silver Spring, Maryland 20906 10 31. Date filed (Month Day, Year) 9 2011 State Registrar's Signa Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 19, Day 2011 Year Eileen Theresa Daniel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3208 Curtis Drive #201 Prince George's Temple Hills 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F New Jersev 238-98-8556 49 196<u>1</u> **Director** Nov Usual Residence of Decedent 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 ☐ No Maryland Prince George's Temple Hills 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 3208 Curtis Drive #201 23a USA 20748 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. o, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Writer Private other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever ည David Sam Daniel Maureen Plunkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. April Daniel (Sister) 2620 Calliope Way #104, Raleigh NC 27616 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Ardent Cremation Svc. 7/21/2011 Hanover, MD 4 Donation 5 Other (Specify) Signatur of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Asthna Vears Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sleep apnea 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Morbid obesity 24a. Was an Breast cancer 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 XYes Hospital 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1X Natural iniury 5 Pending Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined

Division of Vital

State

CRNP 7450 Albert Road. 3rd Floor, Brandywine MD 20613 Debra Apperson 32. Registra JUL 2 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH 9918 8/15/2011 Jh State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#19a.PerFHPGC7-22-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 11:50a^M COLLEEN KAY GROTZKY Ju1y Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES of HEALTH BETHESDA Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country)
 NE 8. Date of Birth **Funeral** 1 □ M 2 F (Month, Day, Yea uly 15 1 Months Days Hours 307-60-2235 49 **Director** July | Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 21 No NE Hall Grand Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 68801 United States 1504 W.John Street should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager 12th æ SH-14-18- Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Harry James Martens Mary Ann Anderson 19a. Informant's Name/Fielationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health in Randy Grotzy/Husband 1504 W. John Street, Grand Islands, NE 68801 Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of N cemetery crematory or other place)
Westlawn Memorial
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific July 23 2011 Grand Island, NE Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20746 0108 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Multiple Myeloma disease or condition 3 months Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 🗌 Fetal death in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknowh 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🔲 Yes 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier i 🗙 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) 10 Center Drive, Bethesda, MD 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2011

arkel

Smith

2835

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. State em., Registrar #26, per physician, 7/20/11 Certificate of Death E.T, WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ *Month 4:35 P M 17^{pay} 201er Robert G. Hutton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Worcester Berlin 375 Ocean Parkway 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** Country) PA 1 X M 2 🗆 Months Hours Min 87 **Director** 193-18-9440 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Berlin MD Worcester 1 Yes 212 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21811 USA 375 Ocean Parkway 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc. ō ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 'natural", Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene, Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Craft Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill the and Mental item 27 is marked ဂ္ George Arthur Hutton Ella Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 375 Ocean Parkway, Berlin MD 21811 Betty Hutton/ wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date Page 1 injury or (cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 7/19/2011 Millsboro DE 4 ☐ Donation 5 ☐ Other (Specify) First State Crem 22. Name and Address of Facility Burbage Funeral Home 23a. Parn'i. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 108 William St, Berlin Md 21811 Approximate Interval Between Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner DRONAL Secure birdly list or neith on Examine if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury CVP that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year ped the Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 2 🗆 No certificate Yes 2 N 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital: Other: 1 Yes 2 PNo မ 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person wh

o completed cause of death (Item 23a) (Type, Print)

			For State	State of M	aryland		artment of F		and Me		20	1 1	24761	
		_	Registrar 1. Decedent's Name (First, Middle	Last)		Cer	tificate of L	Jeatn_		2. Date of Dea	Reg. N.C. U	1 1	3. Time of Death	٦
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<u>.</u> <u>.</u> <u>.</u> <u>.</u>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If feem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 2	19a. Informant's Name/Relationsh Mary Lee / Daug			1	g Address (Street a Stonemed							1
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ř	within To the comp	2	29b. Signature and title of certifier				29c. Licens				29d. Date sign			_
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0 K	10		30. Name and address of person	who completed cause of c	death (Item	23a) (Type, F	Print)					·		_
W [*]			Vijaya Guduri,	M.D. 2403			ch Road	Ho11	Lywood	1, MD 2	0636			_
	Stat	te	31. Date filed (Month, Day, Year)	2011 3. Registr	ar's Signat	re	del							

DHMH 17 Rev 7/2009

		•	For State Registrar	State of Ma	•	epartment of H Certificate of D			2011	24762			
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	Medic Examin	al	ROY 4a. Facility Name (if not institution, gi		LL	4b. City, Town, or	Location of Death	July 1	7, 2011 4c. County of Dea	4:45 A M			
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	and show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
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	with the s 23a o	Funeral Director	4819 Lynn Crest	Court		217	770	10	g. Citizen of What Co USA	ountry?			
030	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates.		13. Was Decedent of His If Yes, specify Cubar1 ☐ Yes 2 ☑ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:				
9500-61212		Completed	15. Decedent's (Specify only highest	grade completed)	(G	ecedent's Usual Occupa ive kind of work done do b. DO NOT use retired)	ition uring most of work	ing 10	6b. Kind of Business	Industry			
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land	d be filed Aental H Irked of tic ever	To B	17. Father's Name (First, Middle, Las Clyde Frank				18. Mother's Nam Ethel	e (First, Middle, Ma	iden Surname) Mahan				
, Maryland	nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relationship Verna M. Hill/Wi		1	lailing Address (Street a				p Code) 1770			
Baltimore,	age 1 ar ent of He nt: If iter y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3		cemetery, o	sposition (Name of crematory or other place	e)		0c. Location - City or				
altil	ermit. Pa epartme nportan ny injury		Stauffer Crematory 7/18/2011 Frederick, 1. Signature 1 uneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home										
П	205 20	n 138	23a. Part 1. Enter the disease, or co	molications that caused t		1621 Opossu				21702 Approximate			
F	nysician/ Medical	V S	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	NEUMO					Interval Between Onset and Death			
	≟xaminer	L	Sequentially list conditions,		consequence of):	EXACERB	MOTA						
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence oi).								
	icate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
09/99	rtificate ing phy e as the	/Med	IF FEMALE:	- u.									
. Box c	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. To the Funetal Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal death	3	У		23d. Date of de Month	blivery Day Year			
ds, r.u.	quires that 1 en signed b ould be deta	by	Part II. Other significant conditions	contributing to death but	t not resulting in the	ne underlying cause giv	en in Part I.		cco use contribute to	o the cause of death? Probably 4 Unknown			
Vital Records,	The law re ate has be page 2 sho	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of			
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5	ng Phy fter this ineral d	ite: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	nt 2 ER/Outpa 28b. Tim Year) inju	e of 28c. Injury	at	28d. Describe how	ce 6 Other (Special or Grant of Control of C	опу)			
DIVISION	Attendii r death. ctor: Al	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	be 280 Place of Injur	y - At home, farm,		Yes 2 □ No	28f. Location (Stre	et and Number or Ru	ıral Route Number,			
<u>≥</u>	oital or urs afte ral Dire			building, etc.				City or Town,					
	No the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Exa only one) 3 Certifying N	nysician: To the best of miner: On the basis of exaurse Practioner: To the b	amination and/or in	vestigation, in my opinio ge, death occurred at the	n, death occurred a time, date and place	t the time, date and ce, and due to the ca	place, and due to the ause(s) and manner as	cause(s) and manner stated.			
9	with To 1		29b. Signature and title of certifier	D.B.	_	29c. License	71068	296	d. Date signed (Mont	th, Day, Year)			
?	P			ma Naic	lu 40	oe, Print) OWEST	th St.	reet, Fre	aderick	mD, 21701			
	Stat Registra		31. Date filed (Month, Day, Year)	2011 32. Registrar		park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24763 amended item#10-wchd-te-7/19 Prificate of Death State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 6, Physician/ Nellie Blanche 2011 Henry 7;50 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1105 S. Schumaker Dr. Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 08/20/1913 Maryland Director 219-36-5829 97 Usual Residence of Decedent or 28a-f shov e notified at 10b. CounSARASOTA should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits FEGREDA 10c. City, Town or Location VENICE Director 1 X Yes 2 X No Maryland Wicomico-Salisbury-34292 10e. Street and Number 1/5/50 BELFRY DR 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1105 S. Schumaker Drive 21804 USA "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Maude Blanche Wilson) marked Charles Masters Wright t. Page 1 and 2 should be to treent of Health and Menta tant: If item 27 is marked jury or other traumatic en 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10077 Locust Point Rd., Princess Anne, MD 21853 Keith Henry/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of H Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 7/14/2011 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Shratur of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) auc? 6 cm 4 Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant qonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 2 🗆 No 1 Yes of Vital 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 TResidence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Division 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of ٥ 29c. License number 29d. Date signed (Month, Day, Year) 71121u US 00 C nd address of person who completed cause of death (Item 23a) (Type, Print) lecy, m2) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Hyle 0500 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lisbury Rehabilitation + Nursing Wicomica Funeral If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign ge (In) 86 1 M 2 □ F Days Months Hours Min. (Month, Day, Year, 2/25/1924 Country) 220-26-3783 **Director** Pennsvlvania Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Hebron 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Barbara Ave. 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

X Yes 2

No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 X Widowed 4 □ Divorced If Yes, Give Specify: White Completed Navy Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Absolum Frank Hyle Laura B. Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sabo/daughter PO Box 98, Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomico Memorial Park 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee ²²Namand Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause operate line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to for as a consequency Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of); resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ To the Funeral Director; After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 4 After this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 4 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 4 Natural injury 5 Pending work? death. Accident Investigation 2 🗌 No within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. MID 31. Date filed (Month, Day, Year State JUI Registrar

			For State Registrar	State of Ma		artment of F rtificate of I			ene 2011	24765
	Bt		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Joseph Henry	Heckrot	te, Jr.			July	19 201	
-	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of De	
~			27678 Wilhelm Roa		O I I birth do	Denton If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Carolin	
	Funeral Director		215-52-4229	YM all E	(In yrs. last birthday 2 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 13	Year) 1949 M	irthplace (State or Foreign Country) aryland
	show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Funeral Director	Maryland Carolin 10e. Street and Number	e	Denton	10f. Zip Code		10	g. Citizen of What	Country?
	with yar	Ö	27678 Wilhelm Roa	d		216	529		U.S.A.	
	ms 2;	Jera	11. Marital Status	12. Was Decedent E	ver in U.S. 13	Was Decedent of H		ecify Yes or No-	14. Race - Ar Black, Wi	merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Worldon Event and the notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:)	1 ☐ Yes 2 X No	Specify:	rican, etc.)	Specify:	White
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	and fealth im 27		Jason D. Heckrott	e/ son		78 Wilhelm			20c. Location - City	
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Bal	permit Depar Impor any ir once.		21. Signature of Funeral Service Licens	see	, I	zz. Name and Addre Fleegle ar	nd Helfen	BOX 10U hein Fun	; Greenso eral Home	oro, MD 21639
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			shock, or heart failure. List only of	one cause on each lin	θ.		· /	or roopilatory arr		Interval Between Onset and Death
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	deat e atte	icia	in the past 12 months? 1 □Yes 2 □No	4 Pregnant at		Other (specify)			Month	Day real
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sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		At home form		Tyes 2 □ No	28f Location /S	treet and Number of	or Rural Route Number,
Division of	or At fter d direct in by	Certification: To	4 Homicide determined	building, etc	ry - At home, farm, c. (Specify)	street, lactory, office		City or Tow	n, State)	, Tural Floate Flames,
	pital ours a eral C		29a, Certifier 15 Certifying Ph	ysician: To the best	of my knowledge, de	ath occurred at the	time, date and plac	e, and due to the	cause(s) and mann	er as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)	niner: On the basis o and manner sta	f examination and/or	investigation, in my	opinion, death occ	urred at the time,	date and place, and	due to the cause(s)
	o the ithin o the omple	Mec	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (A	Month, Day, Year)
	FSFö		ned 4.	ni.	cici .	D.	052255		07-2	1- 2011
			30. Name and address of person who		SiC(AL) eath (Item 23a) (Typ				0,-0	1-
			Muhammad Es	P	Chesal	eake by	Cambo	id90 ,1	MD 216	/3
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11-05547 Kevin Eugene Holland Plea

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State of Maryland / Department of Health and Mental Hygiene		-	24/00
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		l- For State Registrar		Certific	cate of	Death			Reg	. No.		
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd Kevin		olland				j	Date of Death Month I uly 25, 201	11	rear .	3. Time of Death 1046 hrs
		4a. Facility Name (if not institution Calvert Memorial Hos		r)	4	b. City, Town, o Prince Fred		of Death		4c. Coun Calve	ty of Death	
Funeral Director	2	5. Social Security Number	6. Sex 7. A	ge (In yrs. last b	irthday) Yrs.	If Under 1 Yes		Min	. Date of Birth $08/29$		Foreign	nplace (State or n Intry) MD
iland -f show any ouce.		Usual Residence of Decedent 10a. State 10b. County MD Calv		10c. City, Tow		Freder	ick					10d. Inside City Limits 1 Yes 2 X No
with the Maryland as 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 520 Dorsey F	≀oad			10f. Zip Code 2067	78		100	g. Citizen of USA		try?
er death	by Funeral		1 X Yes 2 vorced If Yes, Give Year 1	974-19	1	B Decedent of Hises, specify Cuba	n, Mexican, o specify:	Puerto Rica	an, etc.)	Specif	hite, etc. g:B 1 a c	
24	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 1 2		5+)	during mo	's Usual Occupa est of working life Notive	e. DO NOT	use retired)		16b. Kind of Auto	Business/Ir	
	8	17. Father's Name (First, Middle Eugene	J. Ho	lland				s Name (Fir Lesti	st, Middle, Ma N C	aiden Surnai ${ m I}$.	_{me)} Jac	ks
MD 21215 d 2 should be file th and Mental H n 27 is marked o		19a. Informant's Name/Relations Deborah Holl	ship(Type, Print) .and/siste:	r 5	520 I		Rd.	Prin	ce Fr	ederi	ick,	MD20678
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other S	pecify:		atory or oth C • V 6		m.	8/2/	2011		tenha	ım, MD
		21. Signature of Funeral Service	. Sewell	,								e, P.A. .,MD20678
Physician /Medical £xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	Cardiovascul			, such as ca	ardiac or res	spiratory arres	it, snock, or	neart	Approximate Interval Between Onset and Death
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certif	cian/	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	I LIVO DIII II	ome of pregnanc	2 Fet	al death 3 er (Specify)	Ectopic	pregnancy		23d. Date Month	of delivery	ay Year
P.C es that igned	2	Part II. Other significant condi	ilons contributing to dea	th but not resulti	ng in the ui	nderlying cause	given in Par	rt I.				he cause of death? ably 4 🗹 Unknown
cords	Completed		3					_	24a. Was an autopsy perform	red?		opsy findings available ompletion of cause of S
tal Recion: The certificate ector, page	8	25. Was case referred to medica examiner?					e of Death (
of Vi	의	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ient 2 🗹 ER/0	. Time of In		ury at Work?		ome 5 R			
ion of vertending Physeath. tor: After the funeral		1 Natural 5 Pen	(Month, Day,	Year)		_	Yes 2			,,		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Cou		njury - At home,	farm, stree	t, factory, office	building, etc	c. 28f	Location (Str or Town, Sta		mber or Rur	al Route Number, City
9 - 3 > 1	edical	one) 2 Medical Exa	hysician: To the best of n aminer:On the basis of exa and manner stated	amination and/or								
	Σ	29b. Signature and title of certific	m()			29c. Licens	se number .M.E.		- 1	29d. Date si July 26 , :		th, Day, Year)
v		30. Name and address of person Pamela E. Southall, N				W. Baltimor	re Street,	, Baltimo	re, MD 212	223	_	
Sta Registr	1324	31. Date filed (Month, Day, Year)	2011 32 Registr	ar's Signature	par	w						
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			For	State	of Marylan		artment of H		lental Hyg	iene			
			1 - State Registrar			Cei	rtificate of L	Death	Re	eg. No.)	111	21,767	
10	4		1. Decedent's Name (First, Middi	e, Last)					Date of Deat Month	h Day	Year	5. Time of Death	
	Physicia		Ruth		Yost		Ivers	3	7.	19	2011	12:20 A M	
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n				Location of Death		4c. Cou	4c. County of Death		
V	7 %		Harrison Senio	r Living			Snow Hi	111		Wo	rceste	er	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)	
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	2 .		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Lo	cation		*			10d. Inside City Limits	
-	shov shov dat	Ŀ			100. 011							1 k∏ Yes 2 □ No	
3	Re IN	Director		omico		Salis	10f. Zip Code		1	na Citizen	of What Cou	ntry?	
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-	ns 23	eral	231 Canal Park		pt. A103 cedent Ever in U.	S. 13.1		21804 Ispanic Origin? (Sp	ecify Yes or No-	14. F	USA Race - Ameri	can Indian,	
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	r / z rours arer death with the Maryka "natural", or items 23a or 28a-f shov adical Examiner must be notified at	b	3 ☐ Widowed 4 ☐ Divorced	If Yes. 0	live		1 □ Yes 2 🔀 No	Specify:		Spe	cify: Whi	Lte	
5	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busin (Specify only highest grade completed) (Give kind of work done during most of working									f Business/Ir	ndustry		
2	10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What I county 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What I county 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What I county 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What I county 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10g. Citizen of What I county 10d. Zip Code 10d. Zip Cod												
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2	Ment Ment arked atic e	2	Herbert	Fran	cis	Ive		Ruth	Bran			Yost	
0	and and is ma		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or To	wn, State, Zi	p Code)	
	Health tem 27 is		John B. Robins	IV - Per								Ot-1-	
ָ ס	permit. Pages I and Z Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from		Place of Dispo cemetery, crea	osition (Name of matory or other plac		Date	20c. Locatio	on - City or T	own, State	
	ment ant:		4 Donation 5 DOther (Ro		ek Cemete					D.C.	
<u>ק</u>	permit. Depart Import any inj once,		21. Signature of Funeral Service	Licensee	1//		2. Name and Addres						
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			23a. Parti. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the deatl each line.	h. Do not en			or respiratory arr	rest,		Approximate Interval Between Onset and Death	
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2	edical xaminer		resulting in death)		o (or as a conseq		. Do	m					
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0070	cate be executed physician and the burial-transit	ョ				,							
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	atter	cial	in the past 12 months?	4□Pre	e birth 2 ☐ Feta gnant at time of d		□Ectopic pregnancy □ Other <i>(specify)</i>	/			Month	Day Year	
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L	s mar ned b deta		Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?	
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5 8	erthi eral d	lite ii	27. Manner of Death	(4.0	te of Injury onth, Day Year)	28b. Time o	of 28c. Injur Wor		28d. Describe h				
2	ath. T: Aft	atio	1 ■Natural 5 □ Pendi 2 □ Accident invest	ng (Wi	Julii, Day Teal)	injury		Yes 2 □ No					
2	Atte	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod 200. Fld	ce of injury - At he	ome, farm, st	reet, factory, office		28f. Location (S		umber or Ru	ıral Route Number,	
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	hour uner uner			ing Physician: To t									
	lo the hospital or Artending Prysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	cne)	and ma	anner stated.								
i	Natt of Co	2	29b. Signature and title of certifi				29c. Licens			1	. 1 .	h, Day, Year)	
	~		P 0x	J. W.			002	1/2		1 1	114	711	
,	SK		30. Name and address of perso	n who completed ca	use of death (iter	m 23a) (Type	Print)	CT. 201.	MAKE	Cini	MI	21851.	
			SHARAD R S	SATYAL,	Beistrar's Signs	ature	MICKET	01.104	MORE	414	(1)	21331	
	Sta Registi			0 2011	A LANA	1 1	have					21851.	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 24768 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Albert July 8:45 a.₩ Kerr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Hours Min 02/12/193 Country) Massachusetts Director 023-24-9396 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 45739 Rose Lane 20634 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces?

1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced If Yes, Give Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry Jid be model in the state of th (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Albert Kerr, Sr. ADOLC,
ut. Page 1 and 2 shour.
To Health and Me
To 25 m7 Eileen Agnes Bagge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Mattingly/Daughter Parlett Morgan Road, Mechanicsville, MD 20659 40672 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) b9/08/2011 Arlington, VA Arlington Nat<u>ional</u> Signature of Ineral Seprice License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield. 20650 M00052 122955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final METASTATIC LUNG CANCER Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to him addate cause. Enter Underlying Cause (Disease or linjury Que to for as a ponsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trans attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 4 Pregnant at time of death
9 Unknown signed by the a 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Jonknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 118.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

EENA

31. Date filed (Month, Day, Year)

RAO

JUL 27

KODALI

29449 Charlotte Hall Road, Charlotte Hall, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>011</u> Physician/ Month July 11:00 PM Bertha Jane King 15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Damascus 11411 Kingstead Road 5. Social Security Numbe 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Jan. 18, Year 1935 Months Hours Min. Maryland 217-36-6947 76 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Damascus Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20872 11411 Kingstead Road 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bertha М. Bea11 Leslie C. King Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 20872 11411 Kingstead Road, Damascus, Maryland Mary King - Sister other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 injury (Upper Seneca Cemetery 7/19/2011 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home Signature of Ineral Service Licensi any and Ridge Road, 26401 20872 Damascus, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ITIC disease or condition resulting in death) Medical Due to (or as a consequence of) ≟xaminer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed pertens and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical veac Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe osteoarthritis 1 Yes 2 X No 3 Probably 4 Unknown Completed Ohesi director, page 2 should cf 24b. Were autopsy findings available prior to completion of cause of 24a. Was an endonetrial cancer has autopsy perform death? certificate 1 Yes 2 No 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: 4 \square Nursing Home 5 \boxed{X} Residence 6 \square Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

Joanne L. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kinney, M.D.

2011

🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D34682

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

9701 New Church Street, Damascus, Maryland

29d. Date signed (Month, Day, Year)

July 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1245 PM Rita Lacks 07 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Wicomico Salisbury at the HOSPICE. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Security Number 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🗓 F Hours Min (Month, Day, Year) - 18 – 1929 Months Days 098-20-9275 Yrs New York 82 **Director** Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Wicomico Hebron 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6674 Oak Ridge Drive 21830 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: sp Bilack 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Natural Museum Elementary/Seconday (0-12) College (1-4 or 5+) 12 History Customer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Annie Slow Era Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genice Taylor/Niece 309 Penn Street, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

rect Cremation. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-2011 Dover, DE 22. Name and Address of Facility 917 W. Isabella St. Signatur Bennie Smith Salisbury, MD 21801 Funeral Home
enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -VICAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the g Unknown g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy performed death? eral Director: After this certificate I filled in by the funeral director, pag 2 1 N Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 WNo 1 Tes ျ 1 Inpatient ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 \sum Yes 2 🗌 No hours after death. ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State 19

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 **Physician** 2011 10:39 AM July Mae Lofland Clara /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 16455 Henderson Road Caroline Henderson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🔀 F Director Dec 20 1944 Delaware 213-44-2344 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shor 1 ☐Yes 2 No Maryland Maryland Caroline Henderson Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16455 Henderson Road 21640 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Marical Examinat once. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo White \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Hickman Elsie Clandaniel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl O. Lofland/ 16455 Henderson Road; Henderson, Maryland 21640 husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Templeville Cemetery July 25 2011 Templeville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA efl Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed sician and burial-trans Due to (or as a consequence of) physician the burial Physician/Medical attending ase yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death Yes 2 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to be ath but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 Jemylin atino 1014 neuri 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No MSICHOY 24a Was an has autopsy performed? Yes 2 No 201 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

P.O. Box 68760, Division of Vital Records, Physician:

3altimore, Maryland 21215-0036

he Hospital or Attending PI in 24 hours after death. he Funeral Director; After the pletely filled in by the funeral

ပ

Certification:

Medical

Hospital: 1 Inpatient 5 Pending investigation

2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

200 Chestertown, mp 21620

(Check only one) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

29c. License number 96080

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

1 ☐ Yes 2 🗖 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Registrar's Signa

DHMH 17 Rev 1/2001

To the Hosp within 24 ho To the Fune completely f

State of Maryland / Department of Health and Mental Hygieren Certificate of Death Reg. No. 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) 10 Pay **Physician** 20 1 1 Alesia Ann Miller July 2:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Westminster 449 Bankard Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 💢 F 47 218-92-6427 28, 1964 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow the Medical Exercitive must be notified at Maryland Carroll Westminster 1 ☐ Yes 2 No Director 10f. Zip Code 21158 10g. Citizen of What Country? 10e. Street and Number 449 Bankard Road United States or Itema 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Ia markad other than "natural", or Item any injury or other traumatin. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify. ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) county government clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sudie V. Craiq Lambert H. Miller, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 Bankard Road Westminster, Maryland 21158 Mark Steven Miller/husband 20b. Place of Disposition (Name of cemeter, crematory or other place)
Kirkridge Presbyterian July 13, 2011 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Manchester, Maryland Cemetery 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 21. Signature of Funeral Service Licens M01072 1 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death metastatic Immediate Cause (Final disease or condition resulting in death) PRAH CELL **Physician** 24810 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requiras that the death certificate be exacuted the burial-transit Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 mon Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No this certificate after death.

Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only Other: 4 Nursing Home 5 Versidence 6 Other (Specify) Hospital: ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MILL 2011 5 2117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUR WESTMINISTER MARYUM 291 STONEL I HOMASK GALVINI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrai

			1 - State of Maryland / Dep	partment of Health and I partificate of Death		ene g. N201	1 24773
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medio		David Lloyd Moore		July	$2\overset{\text{Day}}{3}$, $2\overset{\text{Ye}}{0}$	ar 1 5:34 P M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D	Death
_	à.		44670 Willow Oak Court	California		St. Ma	ry's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	(ear), 9.	Birthplace (State or Foreign Country)
	Director		084-34-8899 TAMEZ OF 69 Yrs.		(Month, Day,) 01-20-1	1943 1	Vew York
	nd how at		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	laryla 3a-f s ified	ect	Maryland St. Mary's Califor	mia			1 🗆 Yes 2 No
	the M or 28 e not	吉	10e. Street and Number	10f. Zip Code	10	g. Citizen of What	t Country?
	with 1	Funeral Director	44670 Willow Oak Court	20619		U.S.A.	
	tems er mi	14. Race - A	e - American Indian,				
ထ္ထ	fter d , or i	by	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	nicali, etc.)		Vhite, etc.
g	urs a tural' al Ex	Completed	3 LJ Widowed 4 LJ Divorced Year or Dates.				Vhite
7	72 ho "na" r ledic	l ple	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 1	6b. Kind of Busin	ess Industry
12	ithin ene. r thai	ပ္ပ	Elementary/Seconday (0-12) College (1-4 or 5+)	trumentation		Air Cra	ft
Ö	led w Hygi othe	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
Jan	l be fi fenta rked tic ev	욘	Fred Moore	Margar	et Gilde	rsleeve	
Maryland 21215-0036	thould and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rui	ral Route Number, C	City or Town, State	, Zip Code)
Σ	nd 2 sealth n 27 er tra		Ruth C. Moore / Wife P.	0. Box 3 <u>04</u> Cutch	gue, NY	11935	
ore	e 1 ar of H∉ Hiter Proth		20a. Method of Disposition 1 □ Burial 2 🗶 Cremation 3 □ Removal from State 20b. Place of Disposition	position (Name of ematory or other place)	Date 2	20c. Location - Cit	y or Town, State
Ĕ	Page 1 ment of l tant: If it		4 □ Donation 5 □ Other (Specify) Brinsfie		6-2011		te Hall, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Valley William V	22. Name and Address of Facility Br			
_	5D = 60		Edward N. Brinsfield, Jr. M00052	22955 Hollywood R			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
a	Ph sician/ Medical		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic C	ardiovascular Dise	ease		7 years
	Examiner		Due to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	d d ansit	Examiner	Cause. E. ite. Underlying Cause (Disease or linjury that initiated events c.				
	exectan an an rial-tr	Ĕ	resulting in death) Last Due to (or as a consequence of):			-	
9	death certificate be executed ne attending physician and ed for use as the burial-transit	dical	d				
687	rtifica ing p e as t	Me	IF FEMALE:				
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ğ	the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 g ☐ Unknown	Other (specify)			,
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ŝ	requires that the de been signed by the should be detached	ed by			1 🗌 Yes	s 2 No 3	Probably 4 🖔 Unknown
000	v requ	Completed			24a. Was an	24b. Wen	e autopsy findings available r to completion of cause of
ခ္ခ	he lay te hay age 2	E O			autopsy perform 1 Yes 2	red? deat	th? Yes 2 No
a	ian: T rtifica rtor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Che		-2 NO 1 C	103 2 2 110
₹	nysic nis ce direc	10	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 X Resider	nce 6 Other (S	Specify)
o	ng Pl		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work?	28d. Describe how	v injury occurred	
lo	tendi death tor: A the fi	iji iji	2 Accident Investigation	M 1 Tyes 2 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,		r Rural Route Number,
	spital nours neral filled		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, a	and due to the cause	e(s) and manner a	s stated.
	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inventor only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred	at the time, date and	place, and due to	the cause(s) and manner stated.
	To the voithing complete compl		29b. Signature and title of certifier	29c. License number		d. Date signed (M	
)		• WWW. Washing	D0031563		July 2	6, 2011
2.2	م		30. Name and address of person who completed cause of death (Item 23a) (Type		000 7	. ~	-1- MD 20652
CI I			Charles M. Benner, M.D. 20945 Gre	at Mills Road #	203 Lexi	ngton Pa	rk,MD 20653
	Stat Registra	ar	31. Date filed (Month, Day, Year) 37 Registrar's Signature	we			
_							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g918,08,119/2011dhb Certificate of Death for State Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical **Examiner** 4c. County of Death Baltimore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day **Director** Kentucky show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Wicomico Willards 1 Tes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 36076 Poplar Neck Rd. 21874 USA items ? be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2X No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: white "natural", Completed 3 Widowed 4X Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Automotive repair Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernie Miller Dorothy Hurley traumatic and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36076 Poplar Neck Rd. Willards, MD 21874 Department of Health a Important: If item 27 is any injury or other trau Judy Calloway / personal rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2-XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 07/16/2011 Delmar, DE re of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Cardiac Embolism Sequentially list conditions, if any leading to impose cause. Enter Underlying Examiner Due to (or as a ponsequence of Cause (Disease or iinjury that initiated events resulting in death) Last Ventricular Standstill and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No Yes Vital Hospital or Attending Physician; director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No 1 Yes Other: မ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, After this funeral Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work?
1 Yes within 24 hours after death.

To the Funeral Director, A 2 🔲 No filled in by the Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the only one Certifying Nurse Practioner: To the best of my knowle 29b. Signature

State Registrar

TO

			For State Registrar	State of M	laryland		artment of F tificate of L		d Mental Hy	giene Reg. No.	11	24775		
	Physicia		1. Decedent's Name (First, Middle,	ŕ					2. Date of De Month		Year	3. Time of Death 19:29 M		
	Medi Examii		George Baxte: 4a. Facility Name (if not institution,	give street and number)	1	dec	4b. City, Town, or	Location of De	ath	4c. Coun	ty of Death	h .		
	Funeral				ge (In yrs. las		If Under 1 Year Months Days	If Under 24 by Hours Mi		(Month, Day, Year) County				
	Director	1.	219-14-3960 Usual Residence of Decedent	T GALIN 2 ST	8				July 4	1924	Nor	th Carolina		
	/aryland 8a-f sh tified a	Director	MD 10b. County Wic	comico		Town or Loc lmar	cation					10d. Inside City Limits 1 ☐ Yes 2 ※No		
	ith the N 3a or 2 t be no	ral Di	10e. Street and Number	D 1			10f. Zip Code			10g. Citizen of		untry?		
	death witems 2	Funeral	32033 E. Line	12. Was Decedent	Ever in U.S.				Specify Yes or No-	U.S.		rican Indian,		
036	s after c ral", or Examin	þ	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	No WWI	1	Yes, specify Cuba		erto Rican, etc.)	Bia Specif	ack, White	e, etc. vhite		
15-0	72 hour n "natur ledical	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	ent's Usual Occup-		rorking	16b. Kind of				
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 8	5+)		NOT use retired) mechanic			auton	nobil	es		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, La James Albert	,					lame (First, Middle, a Jane Hu		ne)			
Jany	should and M is mar		19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street a	and Number or I	Rural Route Numbe	r, City or Town,	State, Zip	Code)		
re, N	1 and 2 f Health item 27 other t		Edna McKelvey 20a. Method of Disposition		20b. Pla		E. Line	Road	Delmar, M	D 2187		Town State		
timo	: Page tment o tant: If jury or		1 🐼 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		cen	netery, crem	atory or other place 1 Memory	Jul	y 16, 201	l Hebror	-			
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice			\$h	Name and Addres ort Fune: East Gro	ral Home	e eet Del	mar, DE	t 19	940		
ì			23a. Part 1. Enter the disease, or shock, or heart failure. List on	omplications that caused ly one cause on each line	the death.	Do not enter					,	Approximate Interval Between Onset and Death		
	Ph sician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of):											
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68760	rtificate ing phy e as the	/Medi	IF FEMALE:	a										
Box	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3 🗌	Ectopic pregnancy Other (specify)	/			ate of deliventh	very Day Year		
ds, P.O.	law requires that the nas been signed by the e 2 should be detach	by	Part II. Other significant condition	s contributing to death b	ut not result	ing in the un	derlying cause give	en in Part I.				the cause of death?		
ž	The ate pag	Completed							24a. Was a autop perfor 1 Yes	sv	prior to co death?	opsy findings available ompletion of cause of		
/Ita	rsician: The lar s certificate ha director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	ent 2 EF		100	ce of Death (Ch	eck only one)					
on or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,		27. Manner of Death 1 Matural 5 Pending 2 Accident Investigat	28a. Date of injur (Month, Day	γ 28	Bb. Time of injury	28c. Injury	4 ☐ Nursing at	28d. Describe ho			у)		
DIVISION	cal or Atto		3 Suicide 6 Could no 4 Homicide determine		ry - At home . (Specify)	e, farm, stree	et, factory, office	-16-51	28f. Location (Si City or Town		er or Rura	al Route Number,		
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	Son with		29b. Signature and title of certifier	δ.			29c. License	number 7952	2	29d. Date signe				
(4,40		30. Name and address of person whe	o completed cause of de	eath (Item 23	3a) (Type, Pri	nt) 14B, Sal	lisbury	MD.					
	Stat Registra	_	31. Date filed (Month, Day, Year)	11 2. Registra			W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Grace Eleanor Matthews Tuly Medical 2011 7:10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis HealthCare -The Pines Easton Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Hours Year) 216-07-7135 **Director** 95 20 1915 Marvland Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Caroline Federalsburg MD 1XXYes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21632 124 Liberty Road United States 1 and 2 should be filed within 72 hours after death if Health and Mental Hygiene.
If Health and Mental Hygiene.
If the Z is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Grace Matthews Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. White 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 ☐ Divorced Completed Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry (Grad.) Poultry Grower Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilmer Lee Wright Mabel Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Eileen Turbitt/Daughter 124 Liberty Road, Federalsburg, MD 21632 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hill Crest Cem. Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 07/27/11 Federalsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, Signature of Funeral Service Licensee Muhay 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events as the burial-transit and resulting in death) Last or as a consequence of attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 13 pronths?

1 Yes 2 No detached for 5 Other (specify) Month Pregnant at time of death Dav Year the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? certificate 2 🗆 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this Nursing Home 5 - Residence 6 - Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury hours after death. 1 ☐ Yes 2 ☐ No Accident Suicide the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ise of death (Item 23a) (Type Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Janet F. Moore 3:58 A July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 705 Academy Avenue Caroline Federalsburg Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 937 1 □ M 2 🗓 F Months Days July 24 Country Maryland 214-36-7478 Director 73 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland traumatic event, the Medical Examiner must be notified at Director Federalsburg MD Caroline 28a-f 1 ☐ Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21632 Funeral with 23a 705 Academy Avenue United States items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Caroline County and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Teachers Aide Be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Bessie M. Lankford ပ္ Medford R. Coulbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632 permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Michael Darrin Moore/Son 2652 Meadowbrook Road, Federalsburg, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 5 Department or Important: If any injury or once, East New Mkt, Maryland East New Mkt. Cem 07/22/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Cancer disease or condition resulting in death) UNE Medical Due to (or as consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed transi-Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown Unknown as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Funeral Director: After this certificate has , page 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 XNo ပ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 5 Pending death. 2 Accider
3 Suicide Accident Investigation 2 🗆 No pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 29c. License number 18. 053253 140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tresto. Sniezek MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month Da

Janet Moore

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **-**₩pnth Sandra Elizabeth Martin 0859 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Maryland 1 □ M 2 💢 F Days Hours (Month, Day, Year) January 26, 1946 220-52-9627 **Director** Usual Residence of Decedent 28a-f show 10a. State South aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified 1 Yes 2 □ No Carolina Horry Conway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 Elkford Drive 29526 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married <u>8</u> Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hairdresser **Beauty Salon** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Almer Stevenson Betty Phillips permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Martin - Husband 1109 Elkford Drive, Conway, South Carolina, 29526 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State August 01 1 X Burial 2 Cremation 3 Removal from State Rocky Gap Veterans Cemetery 2011 Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Brain stem Physician/ Massive disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of Examir or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 🗀 Unknown Completed peen upin eigth rome tosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? 2(**X**No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar

State

1250 Willawbrook Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABOUL HAWAN CHEEMA

			_ For	Please	State of M					-		egible.	
			State Registrar					tificate of L			Reg. No 2	111	24779
	Physicia Media		1. Decedent's Name	e (First, Middle, Las By Ower	•					2. Date of Dea	lath lath	a Sell	3. Time of Death
June	Examir	er	4a. Facility Name (if	no institution, give	streen and number)	and			a Mucre	h }			None
	Funeral Director		5. Social Security No. 019–20–8		7.Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h v, Year) 27		place (State or Foreign
	land show dat	ě	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Maryla 28a-f	irect	MD	KENT		WOR	CON						1 Yes 2X No
	with the	Funeral Director	10e. Street and Nun 24214 K		POINT DR	TVE		10f. Zip Code 21678			10g. Citizen o	of What Cour	itry?
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status	ed 2 🕱 Married	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	Ever in U.S.	If	/as Decedent of H Yes, specify Cuba	an, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. F	Race - Americ Black, White,	etc.
21215-0036	72 hour n "natu ledical	Completed	(Spe	15. Decedent's Ed cify only highest gra			(Give k	ent's Usual Occup ind of work done	during most of wo	rking	16b. Kind of	Business Inc	
	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me		Elementary/Seco 12	onday (0-12)	College (1-4 or 8	5+)		NOT use retired) CAL ENG			ENGIN	EERIN	3
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	ge 1 and 2 s at of Health a if item 27 i or other tra		JANNETTE 20a. Method of Disp	ANN OWEN	/WIFE	20h Plas		KINNAIR	D'S POIN				
Baltimore,	Page nent c ant: If ury or		1 🗆 Burial 2		Removal from State	cen	netery, crem	sition (Name of atory or other place E CREMA]	i .	Date 5-2011	CHESTE	on - City or To	wn, State
Balt	permit. Page Department Important: I any injury o once.		21. S unat ye of Fur	neral Service Licens	n. 1/61	line	FE 13	Name and Addre LLOWS, H O SPEER	ELFENBEI RD. CHES	N & NEWN	NAM FUN	VERAL 1	HOME P.A.
-1	h sician/ Medical		23a. Pair 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List only or Final	lications that caused le cause on each line a	105V	o not enter						Approximate Interval Between Onset and Death
	Examiner	r.	Sequentially hat con	iuitions,	. Mucc	ardial	in-Cu	retign		June	DEVMENTA	Phillip	
	outed nd ransit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	injury	<u>.</u> Conge	Due to or as a consequence of): Congesture Neart allure CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CERTIFICATION APPROVED CONGESTURE CONGESTURE CERTIFICATION APPROVED CERTIFICATION APPROVE							
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. Box 68760	Attending Physician: The law requires that the death certificate b death. Adath. ector. After this certificate has been signed by the attending physis by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3 🔲	Ectopic pregnand Other (specify)	ру			Date of delive	ery Day Year
s, P.O.	v requires that t s been signed b should be deta	d by P	Part II. Other signifi	cant conditions co	ntributing to death b	ut not resulti	ing in the un	derlying cause giv	ven in Part I.				ne cause of death?
of Vital Records,	aw requii as been 2 should	Completed by								24a. Was autop	an 24	b. Were auto	osy findings available mpletion of cause of
Re	sician: The law certificate has b lirector, page 2 s		05 M	44						perfo	rmed?	death? 1 Yes	•
Vita	ysician: is certific director,	To Be	25. Was case referre examiner? 1 Yes 2	. h	lospital:	ent 2 🗆 EF	R/Outpatient	Oth	ace of Death (Che	ck only one) Home 5 ☐ Resid	lence 6 □ C	other (Specify)
o uc	nding Ph ath. r: After th ie funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	5 Pending Investigation	28a. Date of inju (Month, Day	ry 28	Bb. Time of injury	28c. Injun work	y at	28d. Pescribe h	ow injury occ		
			3 ∐ Suicide 4 □ Homicide	6 ☐ Could not be determined	28e. Place of Injubulding, etc	ary - At home c. (Specify)	e, farm, stree	et, factory, office		28f. Location (S	Street and Num	nber or Rural	Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir mpleted filled in	Medical	(Check 2	Medical Examir	ician: To the best of ner: On the basis of e e Practioner: To the	xamination ar	nd/or investig	gation, in my opinio	on, death occurred	at the time, date a	nd place, and	due to the car	use(s) and manner stated.
	To the within 2 comple		29b. Signature and t					29c. License			29d. Date sig	ned (Month, i	
	+		30. Name and addre	ss of person who co		eath (Item 23				L Rallie	10000	MN 2	1201
	Rm Stat	e	31. Date filed (Month	-		ar's Signature		had	<u> </u>	- DUITI	MOLE	1-11/2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY Month Year Joil TW) Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 03-15-1920 Director 91 NY 132 01 4310 Usual Residence of Decedent or 28a-f show notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural" are items. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 6449 Deep Calm 21045 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Kosinski Anastasia Budzrycka other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9542 Joseph Olenski/Son Pamplona Rd. Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Louis Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State 7-23-2011 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. le. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Hyperkalenia Physician/ disease or condition Medical resulting in death) Due t (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or selection exquence of): If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by the and be detached for 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ALTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 \square Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUL 21 2011

Scholer, MD

SCHABELMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOTFRAN (CHARELMAN 5755 CEDAN LN

CEDAR LN.

backer

29c. License number

00070109

LOLUM BIA, MD

29d. Date signed (Month, Day, Year)

JUL

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ Year 40 DN ٢ ra 901 Medical 4a. Facility Name *(if not institution, give street and numbe* 4b. City, Town, or Location of Death County of Death Examiner aro Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day Yea If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 🗆 M 2 **Director** Usual Residence of Decedent 28a-f shov at 10a. State City, Town or Location 10d. Inside City Limits Director must be notified 1 XYes 2 □ No Ì ŏ 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 ☐ Divorced Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th ther omemaker TON traumatic event, Be 17. Father's Name (First, Midale, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Un known 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or any SON Hurloc M1erman of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 rom State 4 Donation 5 Other (Specify 201 22. Name and Address of Facility Signature of Funeral Bolden-Tilghman Mortbary lanson 23a, Part 1. Enler the disease, or complination shock, or heart failure. List only one caus Approximate Immediate Cause (Final Onset and Deali Physician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Examiner ATHEROSCUEROTIC CARDIOVASCULAR DISGASE sque ittally list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and -transit Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END-STAGE DEMENTIA 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No 2 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending hours after death.

Ineral Director: After

d filled in by the fun 1 Natural 5 Pending injury 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) on 24 hours
of the Funeral Differmine Completed filler Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOMINGD ALE AUE + State 19

DHMH 17 Rev 7/2009

Registrar

Baltimore,

68760

Box

P.0.

Records,

Division of Vital

11-05328 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Phyliss Rebecca Potter State of Maryland / Department of Health and Mental Hygiene 2011 24782 1- For State TCHD, 07/22/2011, TLS Certificate of Death Amended, 4a Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Da July 17, 2011 Medical Examiner 1324 hrs Phyllis Rebecca Potter 4a. Facility Name (if not institution, give street and number)

52 Jawite Street

52 Jowite Street 4b. City, Town, or Location of Death 4c. County of Death 52 Jawite Street Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours Min. 1 M 2 F Country) 220-28-1023 04-14-1934 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No "natural", or items 23a or 28a-f shov Examiner must be notified at once. Md. Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ö 52 Jowite Street 21601 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene, and I item 27 is marked other than "natural", o and: If item 27 is marked other than "natural", o or other traumatife event, the Medical Examiner and 3 Widowed Black 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: á 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maid Hotel 17. Father's Name (First, Middle, Lest) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Hall Cecilia H. Turpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selena Dicks / Niece Courtland Lane, Willingboro, N.J. 08046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) partment of Donation 5 Other Specify Richards Mem.Pk 07-23-11 Oxford, Maryland Baltin permit. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St. Easton Md. 2 Easton, Md. 21601 426 Dover nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** sist only one cause on each line Between Onset and Madiesi Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ±xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause: Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed ian/Medical UNPENDED AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Physicia 4 Pregnant et time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed by ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown page 2 should be Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? Yes 2 ✔ No death? Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 V Natural Division death. 5 Pending 1 Yes 2 No To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 24 hours after 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. July 18, 2011 125

DHMH 17 Rev 1/2001

State Registrar Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Day Year)

Ana Rubio MD.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2011 2:25 P M 17 Donald Porter, Sr. Pau1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Queen Anne Hospice of Queen Anne's $\begin{array}{c|ccccc} \textbf{Centreville} \\ \hline \textbf{If Under 1 Year} & \textbf{If Under 24 Hrs.} \\ \hline \textbf{Months} & \textbf{Days} & \textbf{Hours} & \textbf{Min.} \\ \hline \textbf{Nov.} & \textbf{25,} \\ \hline \end{array}$ Centreville Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 75 Director 218-34-9062 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Caroline Goldsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15855 Henderson Road 21636 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. "natural", or it 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify <u>6</u> Specify: White 3 ☐ Widowed 4 X Divorced Completed traumatic event, It a Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) food processing supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Hursey Porter, Sr. Dorothy Esther Roe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul D. Porter, Jr. 252 Merrick Corner Road; Church Hill, MD son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State July 21 2011 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ronne disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housing and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Const 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY 2540 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 20 Registrar

ORIGINAL

855

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ \mathbf{P}^{M} 7:05 <u>Treva C. Ridinger</u> 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** carroll Lorien Taneytown Taneytown Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 5/4/1918 Months Hours Min. Days 93 **Director** 212-32-2556 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 No MD Carroll Taneytown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 USA 100 Antrim Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify:White "natural", 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vern Ridinger Margie LeGore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 Piney Creed Rd., Taneytown, MD 21787 Franklin Ridinger/Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 7/18/11 Mountain View Harney, MD Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 7340 PA 1/340 Littlestown Little's F.H. 34 Maple Ave. that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Luke disease or condition norman Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attendin, completed filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death
Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 🗌 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 KNo ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work' 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Acciden
3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier

DHMH 17 Rev 7/2009

State Registrar

WJL

31. Date filed (Month, Day, Year)

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 1:20 Herman Lee Riffe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Callaway St. Mary's Hospice House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Min (Month, Day, Yea 5-7-1943 Virginia Director 229-58-0398 68 Usual Residence of Decedent 28a-f show 10a, State ir than "natural", or items 23a or 28a-f sho the Me Ical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41470 Pensive Street 20650 United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 A Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Education Principal 5+ any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Riffe Cosby Ratliff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Stephen Riffe (Son) 11305 Lenoir Ct., Fredericksburg, VA 22407 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 ar Department of Hi Important: If itel 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-29-2011 Charlotte Hall, MD Brinsfield-Echols Signature of Funeral Service Licenses

Danielle Ward M01403 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINOMA Physician/ 2) ORO PHARYN X disease or condition resulting in death) MONTHS Medical Due to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No Yes 25. Was case referred to medica the funeral director, Be 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 ▼ Other (Specify) House Other: 은 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural injury s after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, Hospital or Attending Physician: of Vital Division within 2 To the I

> State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

31, Date filed (Month, Day, Yea

AMIR

M.S

egistrar's Signature

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ST. MARY

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.J

KHAN,

29c. License number 168846

HOSPITAL, 25500

29d. Date signed (Month, Day, Year)

POINT LOVIOUT Rd, LEONARDTONON, MD-20650

128/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Reynolds Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Ni comuco -oasto at Social Security Number 6. Sex 1 M 2 □ F Funeral 7. Age (In yrs. last birtl Year If Under 24 Irs 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 02/24/1930 Country) Illinois 327-22-5498 **Director** 81 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Fruitland 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Williams Ave. 21826 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ★ Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: White Completed 3 Midowed 4 Divorced Specify: Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Detailer Car Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Reynolds Catherine Bucholz Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5715 Argyle Dr., Parsonsburg, MD 21849 Mary Holland/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Parsons Cemetery 7/15/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ MULMONAP 1BROSIS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Etal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Certificate: To HOSPICAL Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 5 Pending Natural injury 2 Accident Investigation Could not be Suicide 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) address of person who completed cause of death (Item 23a) (Type, Print) (effunson Jux 31. Date filed (Month, Day, Year) 32. Rec State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25^{Day} Physician/ Month Year James Charles Ryder 2011 July 2:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17901 Daisy Drive Washington Hagerstown 8. Date of Birth (Month, Day, Year) Oct. 24,1934 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🔀 M 2 🗆 F Director Yrs. 220-30-9354 76 Maryland Usual Residence of Decedent 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland dartnent of Health and Mertal Hygiene. ordant: If tiem 27 is marked other than "natural", or items 23a or 28a-f shootant: If tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Maryland Washington *Hagerstown* 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17901 Daisy Drive 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by ☐ Yes 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary D. Petterson Charles E. Ryder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Ryder (Wife) 17901 Daisy Dr. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) July 28, 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Cemetery 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 Tellow 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ SUDDEN CARDIAC OKATH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, MTPERTENSION Chronic 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should OBSTRUCTIVE rucmo marz 24b. Were autopsy findings available prior to completion of cause of death? OLSEASE 24a. Was an autopsy n7 PER LIPIDEMIK 2 🗌 No 1 Yes Yes 2 4 Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 📑 No Other: မှ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending injury ☐ Accident☐ Suicide Investigation after death the 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State)

Registrar

within 2

Medical

29a. Certifier

(Check

only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

actus

AUG 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 340 Mill ST

32. Jegistrar's Signature

Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0018019

HAGERSTOWN

29c. License number

29d. Date signed (Month, Day, Year)

21740

26,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20 | |

	1 = State Registrar	Certificate of Death	Re	eg. No.				
Physician/ Medical	1. Decedent's Name (First, Middle, Last) Althea B.	Rivera	2. Date of Death Month July		3. Time of Death 9:25 P M			
Examiner	4a. Facility Name (if not institution, give street and number) 6632 Pebble Court	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick				
Funeral Director	5. Social Security Number 216-60-8281 Security Number	st birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, August 12	Year) 9. Birth Cour 1952 Mai	place (State or Foreign ntry) y Land			
ING Z1Z15-U036 a filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at to Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Maryland Frederick 10e. Street and Number	Town or Location Frederick 10f. Zip Code			10d. Inside City Limits 1 ☐ Yes 2 🗷 No			
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OU36 Ours after deg tural", or ite al Examiner	1 Never Married 2 Married 1 Yes 2 XNo	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ▼Yes 2 □ No Specify: Cuban 	Rican, etc.)	14. Race - Ameri Black, White, Specify: BL	etc.			
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Machine Operator	ing	6b. Kind of Business Industry Food Manufacturing				
Viand Id be filed Mental Hy arked ott attic even To Be	17. Father's Name (First, Middle, Last) Donald K. Lyles		e (First, Middle, Mi Inez	aiden Surname)				
more, Marylano age 1 and 2 should be file ant of Heaith and Mental I- tit. If item 27 is marked of y or other traumatic even	19a. Informant's Name/Relationship (Type, Print) Tarzenia Rivera / Daughter	19b. Mailing Address (Street and Number or Rure 6632 Pebble Court, Freder			Code)			
Baltimore, n permit. Page 1 and 2 Department of Healti Important: If item 2: any injury or other t	1 ■ Burial 2 Cremation 3 Removal from State Cel	metery, crematory or other place)	Date 29, 2011	Prederick, M				
balt permit. Departr Import any inji	21. Signature of Juneral Pervision Licensee M014	33 22. Name and Address of Facility Keeney & Basford P.A. 106 East Church Street	Funeral Ho	me k. Maryland 2	1701			
e death certificate be executed THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF THE ACT OF T	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, being the first terminately cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of the first terminately cause). Due to (or as a consequence of the first terminately cause). Due to (or as a consequence of the first terminately cause).	ence of):			Interval Between Onset and Death			
ut the death certification of the attending stached for use as Physician/Mc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 L Ectopic pregnancy		23d. Date of deliv Month	rery Day Year			
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The law requires cate has been sign page 2 should b			24a. Was an autopsy perform	y prior to co	psy findings available impletion of cause of 2 No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. When Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. Medical Certificate: To Be Completed by Physician/Medical Exam	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	8b. Time of injury at work? M 1 ☐ Yes 2 ☐ No	nme 5 Resider 28d. Describe how 28f. Location (Stre	eet and Number or Rura				
he Hospital or in 24 hours aft he Funeral Dis ppleted filled in	29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death occured at the time, date and place, an	City or Town,	e(s) and manner as state	ed.			
To the H within 24 To the F complete	(Check 2 Medical Examiner: On the basis of examination a only one) 3 Certifying Nurse Practioner: To the best of my beginning the control of the basis of examination and only one) 29b. Signature and title of certifier	and/or investigation, in my opinion, death occurred at snowledge, death occurred at the time, date and placed stream of the summer of the summ	e, and due to the c	ause(s) and manner as signed (Month,	tated.			
81	30. Name and address of person who completed cause of death (Item 2) Elhamy ESKander, ~	(3a) (Type, Print) 501 W 7th St	reet Fr	ederick, M	1021701			
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	parks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health an Certificate of Death	nd Mental	Hygier	102 _{No} 201	1 24789
	Physicia		1. Decedent's Name (First, Middle, Last) Effie Smith	2. Date	of Death	Day Ye	3. Time of Death ar 4835 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) Doctor's Community Hospital 4b. City, Town, or Location of D Lanham	134		4c. County of D	
	Funeral Director		578-30-8551 62 Yrs.	Min. (Mon	of Birth th, Day, Year 4/192	7)	Birthplace (State or Foreign Country) VA
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AN CH+	or 28g	Funeral Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of Wha	
4	is 23a	nera	1626 E Street Southeast 20003		Uni	ted St	ates
036	ıral", or iter Examiner n		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Sive Year or Dates.	n? (Specify Yes o Puerto Rican, eto	r No- :.)		American Indian, Vhite, etc. Black
Maryland 21215-0036	perfilt. rage I and 2 should be mere whithin 2 hours after beath with the waryland portaint learned the thath and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 8th 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use refired) Housewife	f working		. Kind of Busin	ess Industry
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lary	and Me is mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route N	umber, City		
6, ₹	and 2 3		Casandra Crayton / Daughter 1817 23rd Street, SE 20a. Method of Disposition 20b. Place of Disposition (Name of	E, Washi			y or Town, State
Baltimore,	rage in ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		- 1		
Balt	Depart Import any inj once.		21. Signature 1 Funeral Service License 22. Name and Address of Facility 5538 Mar1boro Pi	Pope Fu ke, For	neral estvi	Homes, 11e, MI	P.A. 20746
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DIVISION OT VITAI RECORDS, lal or Attending Physician: The law requires	s after d al Direct ed in by	Certificate:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		tion (Street or Town, Sta		r Rural Route Number,
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ام #	Within To the comp		29b. Signature and title of ceptifier 29c. License number MDD 582	275		Date signed (M	lonth, Day, Year)
2	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parand Alavi, MD 12150 Annapolis Road, Suite#308, G.				<u>,</u>
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Temmat	-, EID	20,00	
	Registra	ar	JUL 2 0 2011 Bengua B. Jack				

11-05448 Bracy Allen Sink Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bracy Allen Sink	1- For State Registrar		artment of I rtificate of I			Reg.	No. 20	11 2479
Physician/ Medical Examine				 -		Date of Death Month D July 21, 201	Day Year	3. Time of Death 0056 hrs
	4a. Facility Name (if not institution, giv 39072 Golden Beach Roa	The second secon		. City, Town, or Location Mechanicsville	on of Death		4c. County of D St. Mary's	eath
Funeral Director	5. Social Security Number 6. Security Number 1X	7. Age (In yrs. la			Inder 24Hrs. 8 ours Min.	3. Date of Birth (F	Birthplace (State or or oreign Country)Virginia
Roy	Usual Residence of Decedent 10a. State 10b. County		Town or Location			07/03/	1900	10d. Inside City Limits
			chanicsv	ille				1 Yes 2 No
the Maryland a or 28a-f sh tiffed at one Director	10e. Street and Number 40438 Duke Rd.			10f. Zip Code 20659		10g.	. Citizen of What	Country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. not: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic evect, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No		Decedent of Hispanic (, specify Cuban, Mexic				merican Indian, Black, tc.
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1215-0036 Id be filed within 72 hours after fental Hygiene. sarked other than "natural", evect, the Medical Examiner ob Be Completed by 1	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	t of working life. DO No	OT use retired)		Constru	•
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Baltimore, permit. Pages 1 as Department of Hei Important: If ite	1 X Burial 2 Cremation 3 Quantity Donation 5 Other Specify:	Removal from State	crematory or other			5/2011	Waldorf	, Maryland
Balti permit. Departm Importu	21 ignature of Funeral Service Licen	\$60)		me and Address of Fac				
Physician /Medical	/23a. Part I/Enter the disease, or comp failure. List only one cause on ea	lications that caused the death.	Do not enter the	mode of dying, such a	OTCN KO is cardiac or re	spiratory arrest	riotte H , shock, or heart	Approximate Interval Between Onset and
Examiner		Multiple Injuries Due to (or as a consequence of	f):					Death
9	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequence of	f):					
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on of Vital Records, P.O. Box 68760, fending Physiciae: The law requires that the death certificate be executed asth. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial. transition: To Be Completed by Physician/Medical Exition:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth	2 Fetal		opic pregnancy		23d. Date of del Month	ivery Day Year
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of Vital Records, leg Physiciae: The law requires ther this certificate has been signeral director, page 2 should be not To Be Completed						24a. Was an autopsy performe	prior deat	
Vital Rec ysiciao: The his certificate director, page	25. Was case referred to medical			26 Place of Dea				Yes 2 No
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2 S 2 5 2 5 3	1 Natural 5 Pending 2 Accident Investigation	FOUND: Jul 21, 2011 28e. Place of Injury - At ho	FOUND: 0056 hrs	1 Yes 2	V No			d object collision r Rural Route Number, City
G 1 22 25 22 1 22	3 Suicide 6 Could not lead to determined 4 Homicide Certifying Physicia	De		nactory, office building,	390	or Town, Stat 072 Golden B	e) leach Road, Me	chanicsville, MD
To the Hos within 24 h To the Fuo completely	(Check only	 an: To the best of my knowledg On the basis of examination ar and manner stated. 						
F FF S	29b. Signature and title of certifier			29c. License numb	per		9d. Date signed July 21, 2011	(Month, Day, Year)
		completed cause of death (Item	•					
State	Pamela E. Southall, MD 31. Date filed (Month, Day, Year)	Assistant Medical Exar		V. Baltimore Stre	et, Baltimo	re, MD 212	23	
Registra			A book	41				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_u^{Month} Mu Mu Sein 2011 11:33A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8845 Locust Grove Drive Port Tobacco Charles 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🗓 F Days Hours 03703711927 213-55-6603 Director 84 Burma Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 X No Maryland Charles Port Tobacco 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8845 Locust Grove Drive 20677 Burma 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Specify: Asian 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Po Sein Kyin Yon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collins Po Sein/Son 8845 Locust Grove Dr., Port Tobacco, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/23/2011 Charlotte Hall, MD Brinsfield-Echols Cr. 21. Signature of Funeral Service Licensee 22 Briansfile 16 Echols Funeral Home, P.A. 20622 M00817 30195 Three Notch Rd. Charlotte Hall. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to manager cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last True to (or as a consequence of) Examir that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 🗹 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🖁 No Other: ျ 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fi 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) July 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day Y

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	For State Registrar			ificate of l			Reg. N2	011	24792
cian/	1. Decedent's Name (First, Middle, Las	gar Shannon Jr				2. Date of De Month	Dav	Year	3. Time of Death 11:10 P ^M
cal ter	4a. Facility Name (if not institution, give	or bitalinon		4b. City, Town, o	or Location of Dea	July th		2011 County of Death	
	41575 Coach Cour				rdtown			St. Mar	
	000-12-0000	ex 7. Age (In yrs. 1 ▼M 2 □ F 87	" [Months Days				9. Birtl Cou New	nplace (State or Foreigr Intry) York
tor	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loca	ation	-				10d. Inside City Limits
Funeral Director	Maryland St. Ma	ary's L	eonardt						1 X Yes 2 N
ī	10e. Street and Number			10f. Zip Code			_	en of What Cou	untry?
	41575 Coach Coun	12. Was Decedent Ever in U.	S. 13. W	20650		Specify Yes or No-		S.A. 4. Race - Amer	ican Indian
2	1 Never Married 2 X Married	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates.	If	Yes, specify Cuba ☐ Yes 2 🗶 No	an, Mexican, Puer	to Rican, etc.)		Black, White	, etc.
)	15. Decedent's Ed	ducation	16a. Decede	nt's Usual Occup	pation		16b. Kin	d of Business I	
Completed	(Specify only highest grades) Elementary/Seconday (0-12) 12	College (1-4 or 5+)	life. DO	nd of work done : NOT use retired) ighter	during most of wo	orking	Fire	Depart	ment
To Be	17. Father's Name (First, Middle, Last) William Edgar Sh	iannon		•	18. Mother's Na	ame (First, Middle, Garside	Maiden St	umame)	
	19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street	and Number or R	ural Route Numbe	er, City or T	own, State, Zip	Code) 33711
	Virginia Shannon	(wife)	7430 S	unshine	Skyway 1	Lane Sou	th, S	t. Pete	rsburg, FI
	20a. Method of Disposition 1 Burial 2 X Cremation 3		Place of Dispos cemetery, crema	tion (Name of atory or other pla	ce)	Date		ation - City or	
	4 Donation 5 Other (Specific			-Echols		25-2011	Charl	otte Ha	III, MD
	21. Sign Ineral errice Lines	sfield, Jr. MO		Name and Addre		1 Home,	P.A.,	Leonar	dtown, MD
Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or linjury	a. Due to or as a consect		rorta	to C	ance	<u> </u>		Approximate Interval Between Onset and Death
	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	C. Due to (or as a consequence of d. 23c. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet	ancy	Ectopic pregnan	су		2	3d. Date of del	
hysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 ∐	Other (specify) _				Month	Day Year
by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause gi	iven in Part I.				the cause of death?
ted	WILL INCOME) CAD				. 1 🗆	Yes 2		obably 4 🗌 Unknov
Completed by Physician/Medical						24a. Was auto perfe 1 \sum Yes		prior to death?	opsy findings available completion of cause of 2
Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Ch	eck only one)	5"		7
P	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatient		4 ☐ Nursing	Home 5 Resi			(y) Hospice
Certificate:	1	(Month, Day, Year)	injury		ry at k?] Yes 2 □ No	28d. Describe	now injury	occurred	House
Cert	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree y)	et, factory, office		28f. Location (City or To		Number or Rur	al Route Number,
Medical	Check 2 Medical Exami	sician: To the best of my knew iner: On the basis of examination of Practioner: To the best of m	n and/or investig	ation, in my opini	ion, death occurred	d at the time, date	and place, a	and due to the o	ause(s) and manner sta
	29b. Signature and title of certifier			29c. Licens		5		signed (Month	
						,	/		
	•		00.) =	12/	971		-4	12/1	1
	30. Name and address of Serson where Dr. James C. Boyo	completed cause of death (Item			rive To	onardtow	n Ma	ryland	20650

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygie 20

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07-11-2011 758 P Joseph Philemon Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 28985 Sanderstown Rd Talbot Trappe Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 X M 2 □ F Months Days Hours 66 Director 219-46-4860 12-21-1944 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at 1X Yes 2 □ No Director MD Talbot Trappe death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28985 Sanderstown Rd 21673 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🏋 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12 should be filed within 72 hours after th and Mental Hygiene.
7 is marked other than "natural", or iter traumatic event, In Medical Evantina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates: ۵ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Waterman Seafood 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any liginty or other traumatic evance. Joseph Carroll Smith Grace Balderson Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Smith (Wife) 28985 Sanderstown Rd Trappe MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oxford Cemetery 7-15-2011 Oxford, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home P.A. 200 S. Harrison St Easton MD 21601 TOHN R. MERCEROL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic Physician CANCES months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a P.O. 1 ☐Yes 2 ☐No 9 Unknown 9 Ulnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Completed CORONARY 24b. Were autopsy findings available prior to completion of cause of death? spital or Attending Physician: The law nours after death.

The ari Director: After this certificate has to filled in by the funeral director, page 2 sl autopsy perform 1 ☐Yes 2 ☐ No of Vital 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) D 31867 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 511 Idlewild AVE. EASTON MD 21601 FISHER MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 14 2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Trem 25 per med cert G918 8/11/10 dk
State of Maryland / Department of Health and Mental Hygiene 24794 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 7-17-201 Pay SARA L. SCHNEIDER 923 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c, County of Death 8851 Quailsar Rd Easton Talbot Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 😾 F Months Davs Hours Min 12-11-194 Country) Washington **Director** 226-56-5773 69 Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10d. Inside City Limits 10c. City, Town or Location Director Talbot 1 ☐ Yes 2 🏋 No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8851 Quailsar Rd 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 X Married 2**X** No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) 5+Para-Legal Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ J. Carl Downing II Dora Brunner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Schneider, Jr. (Husband) 8851 Quailsar Rd Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Cremation
Center 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 7_18-2011 4 Donation 5 Other (Specify) Stevensville, MD enter 21, Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. MERCERÓ MADE 200 S. Harrison St. Easton, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic disease or condition 7 months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consequence of if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year been signed by the Unknown Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 \sum Yes Other: 2 X No Certificate: To 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 eids l my 31. Date filed (Mant 1 9 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State Registrar	of Maryland / Depa <i>Cel</i>	artment of Health <i>rtificate of Death</i>		giene Reg. NO 11	24795
П	Physicia	m/	Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th	3. Time of Death
particular.	Medic	al		fan		July	17, 2011	6:30 A.M
	Examin	er	4a. Facility Name (if not institution, give street and nu Sunrise Assisted Livi	ŕ	4b. City, Town, or Location Frederick	n of Death	4c. County of Dead	
S. San	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, last birthday)		er 24 Hrs. 8. Date of Birth Min. (Month Day	9. Bir	thplace (State or Foreign
	Director		218-38-7711	69 Yrs.	World Days Hours	Min. 01/16/1	1942	untry) MD
	and show dat	ğ	10a. State 10b. County	10c. City, Town or Lo	cation		-	10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Frederick	Knoxvil	.1e			1 🗆 Yes 2 🖰 No
	ith the 3a or 1 be n		10e. Street and Number 325 E. Mountain Road		10f. Zip Code 21758		10g. Citizen of What Co	ountry?
	ems 2	Funeral	11. Marital Status 12. Was Dec	edent Ever in U.S. 13. \	Was Decedent of Hispanic C		USA 14. Race - Ame	rican Indian,
98	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at , the Medical Examiner must be notified at	by	16 Van C	2 🔁 No	If Yes, specify Cuban, Mexic 1 ☐ Yes 2 H No Speci		Black, Whit	
Ö	ours a aturali cal Ex	Completed	3 Widowed 4 Divorced Year or D	Pates.	dent's Usual Occupation		Specify: WI	nite
215	n 72 h e. ian "n Medi	ldmo	(Specify only highest grade completed Elementary/Seconday (0-12) College ((Give	kind of work done during mo O NOT use retired)	ost of working		
21	d withi ygiene her th nt, the	Be Cc	12		cutive Secret		U.S. Air	force
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Middle, Last) Byron Spieth		18. Mo	ther's Name (First, Middle, I unknown	Maiden Surname)	
aryl	ind Me s marl		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Num		, City or Town, State, Zi	o Code)
Σ	and 2 sl Health a tem 27 i ther tra		John Stefan/husband	325	E. Mountain	Rd., Knoxvil	le, MD 217	58
lore	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 1 once,		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cren	natory or other place)	Date	20c. Location - City or	Town, State
븚	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Stauffer	Crematory 2. Name and Address of Fac		Frederick,	
Ba	permi Depai Impo any ir		MIG. M	/ ~	621 Opossumto			
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. Do not ente	er the mode of dying, such a	as cardiac or respiratory arre	est,	Approximate Interval Between
and and	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Hy	noxia			Onset and Death
	Examiner		Due to	(or as a consequence of)				\$4.4
		iner	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequen e f):	amer!) ecse		Jears.
	ecuted and transit	Examine	Cause (Disease or ilinjury that initiated events c.	(27.22.2.22.22.22.22.22.22.22.22.22.22.22				
0	cate be executed physician and the burial-transii	edical E	resulting in death) Last Due to	(or as a consequence of):				
376(ficate g phys	/ledi	d					
Box 68760	ath certific attending p	Physician/M	in the past 12 months?	tcome of pregnancy Birth 2 Fetal death 3			23d. Date of de	
B0	the at	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unk		Other (specify)		Month	Day Year
P.0	requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to o	death but not resulting in the u	inderlying cause given in Pa	rt I. 23e. Did to	bacco use contribute to	the cause of death?
ds,	quires en sign	ted k	Hypertension			1 🗆 Y	′es 2 No 3 □ P	robably 4 🗌 Unknown
COL	law re nas be e 2 sho	Completed	Hypertension Hypercholaterslemia.			24a. Was a autop	sy prior to	topsy findings available completion of cause of
<u> </u>	n: The ficate I		25. Was case referred to medical					s 2 🗆 No
Vita	ysicial s certi	To Be	examiner? Hospital:	Inpatient 2 ER/Outpatier	_ Other: \ /	eath (Check only one) Nursing Home 5 Resid	ence 6 🗆 Other (Spec	rife)
of	ng Phy fter thi ineral (rte: T	27. Manner of Death 28a. Date				ow injury occurred	
ion	ttendideath.	Certificate:	2 Accident Investigation		M 1 ☐ Yes 2			10
Division of Vital Records, P.O.	al or A s after I Direc d in by			e of Injury - At home, farm, stre ing, etc. (Specify)	вет, тастогу, опісе	28f. Location (Si City or Town	treet and Number or Ru n, State)	raj Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the ba	pest of my knowledge, death (occured at the time, date and	d place, and due to the cau	ise(s) and manner as sto	ated.
	thin 24	Me	only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier			ate and place, and due to the	cause(s) and manner as	stated.
	F ≥ F Ω		Mas A Human	M.)	D 468	/ .	29d. Date signed (Monti	1, Day, Tear)
	r L		30. Name and address of person who completed cau	se of death (Item 23a) (Type, F	Print)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	5		MAAZ- A. HUSSAN.	45. T. J DR	IVE FRE	DERICK J	D 2170.	2
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 9 2011 32.	registrar's Signature	and the			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMENDED ITEM Registrar O WCHD TE 07/22/11

1. Decedent's Name (#irst, Middle, Last) Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month. Elton John Sears 0(45 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisburg Wicomico Poninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** NC Country) 1**X** M 2 □ F (Month, Day, Year) -5-1949 Months Days 62 Director 222-32-4507 Usual Residence of Decedent at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Tes 2 X No DE Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 38 Sunset Drive 19956 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 7 rmx/ within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. or . A Q 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifyBlack "natural", 3 Widowed 4 Divorced If Yes, Give Army Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry e filed wn.. خاط Hygiene. خات تعمد than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Mountaire marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Gapher Walston, Jr. Annie Marie Sears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 Norissa Sears/Wife DE 19956 38 Sunset Drive, Laurel 20b GOLD OF DOOR GRADE OF 20a. Method of Disposition BISHOPVILLE TOWN State Department of H Important: If ite any injury or otl cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Admin Cem 7-23-2011 <u>Millsboro, DE</u> 22 Name and Address of Facility 17 W. Bennie Smith Funeral Home Salisbu Signature of Funeral Service Licenset Isabella St. Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ aspiration disease or condition resulting in death) preummia LOUVE - Medical Due to (or as a consequence of) Examiner ar kinron DICENTE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for his it non-securities Exam Cause (Disease or iinjury and-trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Sacra Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 page death? performe this certificate 2 🗌 No 1 Yes 2, No 1 Yes in 24 hours after death.

he Funeral Director. After this certific pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗋 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pendina work? M Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c License number 29d. Date signed (Month, Day, Year) 'NX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eminiula Regional Medical Center 13. Silvia Tr MD

State Registrar 31. Date filed (Month, Day, Year,

Reg. No. Physician/ edical Examiner Gary 4a. Facilify Name (if not institution, give street and number) 64 Old S. River Road Slip 14 P Government Funeral 5. Social Security Number Grav General 6. Sex 7. Age (In yrs. last birthday) Funeral Certificate of Death Month Day July 15, 2011 4c. County of Death Anne Arundel 4c. County of Death Anne Arundel Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	1-05259		Please Type or Print in Black Indelible ink. Ensure All Copie			
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The state of the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spital cours a neral filled	Cer	4 Homicide	B		
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30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	To the Within To the comp	Med	and manner stated.			
Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Kegistrar's Signature						
Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Kegistrar's Signature			arot Addan			
				D 21223		
	S	tate				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andrew John Sabonis, Jr. Tulv 2011 4:15 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harmony Hall Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Months Min (Month, Day, Year) 06/06/1927 164-22-1069 PA Director 84 Usual Residence of Decedent 28a-f show 10a State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Howard 1 Yes 2 No Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane Apt. 375 21044 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 1945—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White | Hygiene. other than "natural", Specify: Completed 3 Widowed 4 Divorced 1946 Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor, Gen. Engineer US Army Research Lab is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Andrew John Sabonis, Sr. Anna Zipay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Binaut - daughter 9761 Gingerwood Drive Ellicott City, MD 21042 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 07/21/2011 4 Donation 5 Other (Specify) Hanover, MD ^{22. Name and Address of Facility} Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee noll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line DiS2950 Immediate Cause (Final hermers Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Exami death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending p for use as t IF FEMALE - nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Hospital or Attending Physician: The 2 🗌 No Yes 2 No 1 🗌 Yes Vital 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1-Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifier 29c. License number J-14 21, 2011 Freese who completed cause of death (Item 23a) (Type, Print 30. Name and add address 31. Date filed (Month) Pay, egistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20^{Day} Physician/ July 20°1′1 11:10 P M Louis Schwatka Sr. 0wen Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Denton 8895 Andersontown Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours MD Country) Director 212-34-6631 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Caroline Denton Marvland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21629 8895 Andersontown Road death 12. Was Decedent Ever in U.S. Armed Forces?

1 K Yes 2 No 1955 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates. to 1959 "natural", Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 H.S. Grad College (1-4 or 5+) Public Transportation Airline Pilot other traumatic event, permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Herdman Bushrod Schwatka Thelma Alice Reuschling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8895 Andersontown Rd., Denton, Maryland Mary Ellen Schwatka/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory July 21,2011 Dover, Delaware Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sheet and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine arry, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 👼 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

> State Registrar MH 17 Rev 7/2009

Medical

29a. Certifier

(Check

30. Name and address of person who

2 2 201

31. Date filed (Month, Day, Year)

Jensen MD, PDB F69D,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DENTON MD 21629

29d, Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#1. PerPhys. PG state of Maryland / Department of Health and Mental Hygiene 24800 Reg. N2 state Registra Amend#'s5.12. PerFHPC7-25-11cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCELLUS Month 4 Physician/ JULEK 1-20AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sanctuary at Holy Cross Burtsonville 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 599:iat-8ecunt (bumber 571 (-50 - 7558 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 09/08/1937 DC 73 Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than 'natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1x Yes 2 ☐ No MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3504 Lumar Drive 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 1 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. ю þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Albert Tyler, Sr. Ottalee Ethel Fraizer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4803 Richard Ave, Baltimore, MD 21214 19a. Informant's Name/Relationship (Type, Print) Beverly Tyler-Harper/ Daughter 20b. Place of Disposition (Name of Riggs of Place) Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Durial 2 Dremation 3 Removal from State 7-18-2011 Riverdale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses M00981 5538 Marlboro Pike, Forestville, MD 20746 Charle 23a. Part 1. Enter the disease, or comblications that outset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ETASTIATIO ANCREATIC - Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mini solute cause. Enter Underlying Cause (Disease or iinjury Examiner Dan to for se a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown 9 🗌 Unknown Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THROM BOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? NON ST- MYOCARDIAL 24a. Was an certificate has 1 ☐ Yes 2 ☑ No 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 8 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural iniun 5 Pending Accident Investigation Director: Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Meery

JUL 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ACHANI

m

2835

D28595

SMITTH

BARD

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2480 I Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07/138/201\Tear D5:44 A M Sandra O. Townes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 055-32-1861 Months Hours Min. Director 07/06/1941 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director Examiner must be notified MD Prince Georges Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 10240 Prince Pl. apt. 102 20744 AZU items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married "natural", or Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Distribution Office Worker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental rant; If item 27 is marked o 0 Evelyn Carrington Willie McElroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20716 Trov B. Townes / son 15100 Narrows Ln., Bowie, other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 07/16/2011 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signatur of Funeral Service Licens 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, in any, leading to incrediate cause. Enter Underlying Examine Due to (or as a consequence of): Congestive Heart failure Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Clostridium Difficile Colitis Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Pregnant at time of death the Unknown ed by be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 \square Yes ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work? 2 🗌 No 24 hours after death, Funeral Director; A Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

<u>Kanwaljit Nagi</u>

JUL 2 0 2011

56003

1500 Forest Glen Rd., Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:108 Physician/ Twilley Month C. Day Ruth 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death castal b Nicomico Social Security Number Year If Under 24 Hrs. 8. Date of Birth If Unde 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 🗆 M 2🗶 F Months Days Min Hours 0470571929 82 213-24-1220 Yrs Maryland Director Usual Residence of Decedent 28a-f show and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f shorrammatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 1728 Crestwood Circle death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wallace D. Clark Ruth Esham 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. . Page 1 and 2 sl tment of Health a 601 Parker Rd., Salisbury, MD 21804 Victor Twilley/son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1

Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Pittsville Cemetery 7/15/2011 Pittsville, MD permit. Signature of Funeral Service Licens HOTTOWAY FUNERAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph i i n CARCINOUND MALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, n any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) been signed by the atte should be detached for a in the past 12 onths? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed Ves 2 death? certificate 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 10 Other: HOSPICAL 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending within 24 hours after death.

To the Funeral Director: A 1 🗌 Yes 2 🗌 No completed filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de only one) eath occurred at the time, date and place, and due to the ca 29b. Signature and title of certifier

State Registrar

CHUCAM

31. Date filed (Month, Da

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

PO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 24803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucien Withers Month 1510 July 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death feninsyla Nicomico XIISbur 1 <u>Kegional</u> Medical Center If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours 431-17-3205 55 3^M•1^t2 ^D3′,9′5′6 Director Arkansas Usual Residence of Decedent or 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director must be notified DE Sussex Laurel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12223 Chipmans Pond Road 19956 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Pipefitter Heating/Air HAVC permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Robert Withers II Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelina Griffee (Girlfriend) 12223 Chipmans Pond Rd. Laurel, De. 19956 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) First St. Cremation 7-25-2011 Millsboro, Delaware Signature of Funeral Service Licensee 700 West St. 22. Name and Address of Facility Hannigan,Short,Disharoon F.H.Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 attending properties for use as IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery in the past 12 months? Day Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 M Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate l 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 X Yes ပ 1 Inpatient 2 X ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu М 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, I my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) 450497 SILISBURY MD 10 who completed cause of death (Item 23a) (Type, Print) E. CATOI State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Lak Eggy All Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiens Ω 1 1 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month ... Aline Wharton Medical Pacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NICONIC 542/3/11/0 6. Se 7. Age (In yrs. last birthday) If Under 1 Year 9, Birthplace (State or Foreign 5. Social Security If Under 24 Hrs 8. Date of Birth MD Country) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 9 - 18 - 1943 **Director** 219-42-7943 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 XYes 2 No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA Market Street 21851 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: SpeWhite "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nursina <u>Geriatric Aide</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o မ Jesse W. Mariner <u>Mary Morgan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Wilson/Son 32076 Flower Hill Church Rd, Eden, MD<u>21822</u> other : Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of Commetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, 7-15-2011 Dover, DE Bennie Smith 917 W. Isabella St. Signature of Funeral Service Licensee Home Salisbury, MD 21801 Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cerebro Voscu Difeere disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes 3☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🍱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 🗶 No 1 🗌 Yes ၉ ✓Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 1363195 114/11 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ohesh Vohra 100 E · Carroll SAlisbury, md. 21801 5/ 31. Date filed (Month, Day, Registrar's Signat

State

Registrar

Year) 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Physician/ 2205PM Ruth D. Williams 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical Center Miskun Wiamico . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Day Months 217-44-1881 Hours Min. (Month, Day Year) Director 69 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Philadelphia PA Philadelphia 1 X Yes 2 No 10e. Street and Number ms 23a or ö 10f. Zip Code 10g. Citizen of What Country? Funeral 2219 Montrose Street 19145 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" 3★ Widowed 4 □ Divorced SpBikack Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 cal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CNA 11 Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Watson Eleanor Watson 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangeline E. Williams/ 1713 S. Bancroft St, Philadelphia, PA 19145 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Diace) 20c. Location - City or Town, State Department of Important: If it any injury or of once. 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation, 7/20/2011 Direct Dover, DE Signature of Funeral McPherson Funeral Services PO Box 326, Milford, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SERSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CETTOUTEDO Bower Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) al Lirector. After 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 1 🗌 Yes 2 No 6 Could not be within 24 hours after de.

To the Funeral Lirecto
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of pe

31. Date filed (Month, Day, Yea

ar's Signature

St. Salisbury MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kerrigan A. D. 4507 Peer Point or. Soutsbury, M.S. State 31. Date filed (Month, Day, Year) 32. Repistrar's Signature	6876	ertificat ding ph	/Med				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kerrigan A. D. 4507 Peer Point or. Soutsbury, M.S. State 31. Date filed (Month, Day, Year) 32. Repistrar's Signature	ıta I	sician; certific irector,	Be	examiner?	- Other	,	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kerrigan A. D. 4507 Peer Point or. Soutsbury, M.S. State 31. Date filed (Month, Day, Year) 32. Repistrar's Signature	Division	al or Atte s after de I Directo d in by th		4 Homicide determined 28e. Place of Injury - At home, farm,	street, factory, office 28f		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kerrigan A. D. 4507 Peer Point or. Soutsbury, M.S. State 31. Date filed (Month, Day, Year) 32. Repistrar's Signature	_	he Hospitt in 24 hours he Funera pleted fille	Medica	(Check 2 \(\sum \) Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred at the	e time, date and place	e, and due to the cause(s) and manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Kerrigan A.D. 4507 Peer Point Dr. Soulsbury, M.S. State 31. Date-filed (Month, Day, Year) 32. Reflictrar's Signature		To t To t		(C C C C C C C C C C C C C C C C C C C	29c. License number D44688	29d. Da	ite signed (Month, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature		318		30. Name and address of person who completes cause of death (Item 23a) (Type	· · · · · · · · · · · · · · · · · · ·	UM MA	7 11 10 - 11
Registrar			_		A South		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ James Aloysius Wathen 2011 7:53 a JulyMedical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year) 08/11/1929 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 1 ፟፟፟ M 2 ☐ F Hours Director 217-36-9166 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be norther once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 K No Maryland Helen St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 39130 Chaptico Road 20635 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 6 Security Guard Utility Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Harden William Ford Wathen Catherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 39130 Chaptico Rd., Helen, MD 20635 Dorothy J. Wathen/Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Joseph's 07/18/2011 Morganza, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Name and Address of Facility
Mattingley-Gardiner Funeral
P.O. Box 270, Leonardtown, Anne of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician utcas MOXIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

124 hours after death.

Funeral Director, After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Vementia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Hospital: 2 LX No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at 1 Natural work' 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practiener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Pwithin 2 To the P only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 506

State Registrar

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30. Name and address of person who comp

31. Date filed (Month, Day, Year) **JUL 18 2011**

of death (Item 23a) (Type, Print

Registrar's Signature

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Leon Berube, M.D.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DONALD FRANK YERKES Month 7 331A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINS4LA SAL13641 HICOMICO Medical REGIONAL If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Sex 1 **∆** M 2 □ F Days Months 161-16-5847 95 Hours 71915PENNSYLVANIA **Director** Usual Residence of Decedent show or 28a-f shov se notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX SEAFORD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
AMERICA ed other than "natural", or items 23a or event, the Medical Examiner must be Completed by Funeral 19973 9820 NORTH SHORE DRIVE permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?, 1 ☐ Yes 2 🐼 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) JUDICIAL Elementary/Seconday (0-12) College (1-4 or 5+) MAGISTRATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ANNA KERNS ည YERKES ROWLAND JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 110 BUTLER COURT FRUITLAND, MD • 21826 SON DONALD W. YERKES 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State DELMAR, DELAWARE CREMEATOR DEVELOP OF Place)
DELMARVA 1 Burial 2 Cremation 3 Removal from State JULY 4 Donation 5 Dother (Specify) 22. Name and Address of Facility WATSON-YATES FUNERAL HOME, FRONT & KING STREETS SEAFORD, DE. 19973 FRONT & 23a Part 1. Enter the dise shock, or heart allury Immediate Cause (Tipa) , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending М 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G918 8/24/2011 JH State of Maryland / Department of Health and Mental Hygiene 2011 24809 For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year August 1, 2011 3:45 AM Norma Margaret Augerinos 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Encore at Turf Valley Ellicott City
| Funder 1 Year | If Under 24 Hrs. Howard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Days Hours Min. 1 ☐ M 2 🖫 F Dec.31, New York 055-26-0218 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 6201 Lakemont Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ∐Yes 2 X No 3 Nidowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antinette D'Diminico Nicholas Pirone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son 1314 Matson Manor Court; Spring, Texas Lawrence Augerinos 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/30/2011 Arlington National Arlington, VA 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fin ral Service Licensee MD 21228 1630 Edmondson Avenue; Catonsville, Part 1 Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 97(25 rain resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, attending physician the signed by has certificate Hospital or Attending Physician: this

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/Medical

Examiner

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Director

ral", or items 23a or 28a-f shorex and examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with inner of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

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Medical Certification: To

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Name and address

29b. Signature and title of certifier

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6 ☐ Could not be

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completely filled in by the funeral director, within 24 hours after death To the Funeral Director:

State Registrar

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

rers in who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24810 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ NORMAN, ARMSTRO1 0643M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MERCY MEDICAL CENTER BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Days Hours Min. 0 Mg/ 19 19 19 60 51 Director Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 714 N. Port Street U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) unk life. DO NOT use retired College (1-4 or 5+) Construction Demolition Construction Co. is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Chester Eppes Mackie Tann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Mason(sister) 2236 W. Saratoga St., Baltimore, MD 21223 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 07/29/11 Baltimore, MD 21. Signature of Funeral Service Licensee វិទាន់ទេក្រ^{Ad}មិនេះ ^{of}Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death HYPERTENSION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEROSC CARDIOVASCULAR DISAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death
Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce FKZ613772 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL ST, BALTIMORE, MD 21202

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 248 1 State of Maryland / Department of Health and Mental Hygiene

Synthia Bennett		- For State	State	or iviaryiand		rtment of l tificate of l		nu wentai		Reg. No		
Physicia	n/	<u>Registrar</u> 1. Decedent's Name (I	First, Middle,Last)					-	2. Date of De	eath	Year	3. Time of Death
Medical Examin		Cynthia							Month July 26,			1713 hrs
		4a. Facility Name (if n Johns Hopkin		street and number	·)		. City, Town, Baltimore	or Location of D	eath		c. County of Death	
Funeral		5. Social Security Nun	mber 6. Sex	7. A	ge (In yrs. la	ast birthday)	If Under 1 Y		Min	•	/DD/YYYY) 9. Bir Foreig	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	eral Service Licens	see /s Ville	lain	²	sepho 40 N.	雅。 Fulto	wn Jr. n Ave.	Fun Ba	eral Ho	ome PA e,MD 21217
Physician		23a. Part I. Enter the failure. List only	disease, or compl	lications that cause ch line. Subdu	d the death	. Do not enter the	mode of dvi	ng, such as card	liac or respiratory	arrest, sl	hock, or heart	Approximate Interval Between Onset and
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60, ate be es ohysician	Medical	IF FEMALE:		23c. If yes, out			ше, в	710 0 17	7-11 SM	12	3d. Date of delive	
ox 68760, eath certificate be ex attending physician for use as the burial		23b. Was decedent pr past 12 months?		1 Live birth			al death	3 Ectopic p	regnancy			Day Year
Box 687 e death certific the attending p	ysician/	1 Yes 2 No	o 9 🗸 Unknown	4 Pregnant death Unknown	at time of	5 Oth	er (Specify)					
O. B. at the de d by the stached f	y Phy	Part II. Other signific	cant conditions	contributing to de	ath but not	resulting in the u	nderlying cau	se given in Part	. 23e. D	id tobacc		the cause of death?
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Vital Rec ysician: The his certificate director, page	Be	25. Was case referre examiner?	, ,	lospital: 1 🗸 Inpa	tient 2	ER/Outpatient		Other	heck only one) Nursing Home 5	Resi	dence 6 Oth	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide	6 Could not determine	be		nome, farm, stree	t, factory, offi	ce building, etc.	or Tow	n, State)	4017 Libe	tural Route Number, City Erty Hgts. Ave
Divi: To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in b		4 Homicide 29a. Certifier 1 Check only		ian: To the best of			ed at the time	e, date and place	Balti e. and due to the d			ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 V	Medical Examine	r:On the basis of e	xamination	and/or investigat	on, ın my opi	nion, death occu	rred at the time, o	late and	place, and due to	the cause(s)
_ \(\(\)	Me	29b. Signature and ti	itle of certifier					cense number			d. Date signed (M	onth, Day, Year)
0'	î l	_ uue.	12					.C.M.E.			ıly 27, 2011 ———-	
100.	ŧ Į	30. Name and addre Ana Rubio M	-	completed cause on t Medical Ex		-	more Stre	et, Baltimore	e, MD 21223			
γ λυ ' St	tate	31. Date filed (Month	n, Day, Year)		trar's Signa			,				
Regis	trar	AUG 0 4 20	77 Buch	us B.	Dark	Land						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James 1/Samm Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ave <u>1620 Lochwood</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
N.C Hours 1 M 2 D F Min 212-30-5915 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s 1X Yes 2 ☐ No Baltimore MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1620 Lochwood Ave. 21218 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Evol Armed Forces? 1 ☐ Yes 2 💢 No the Medical Examiner Black, White, etc ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates Black 1 ☐ Yes 2 XNo Specify. Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College Park Elementary/Seconday (0-12) College (1-4 or 5+ Brick Layer Contractors other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H မ Louey Dell Farrow James Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Shirley Brooks - Wife 20a. Method of Disposition 1620 Lochwood Ave. Baltimore, MD 21218 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State King Memorial PK. 8/5/2011 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March Funeral Home 1101 salto., MD 21202 Morth Ave. Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STAC Myzyne disease or condition Medical resulting in death) Due to (or at a consequence of) **Examiner** Sequentially list conditions, if a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or de a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Hospital or Attending Physician: The law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes plnods been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 🗌 Yes 2 🗌 N ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after dect Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one Signature 29d. Date signed (Month, Day, Year) 28/ on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#20b, PerFH, G918,8/29/2011, WS
State of Maryland / Department of Health and Mental Hygiene 24813

		-	For State Registrar	State of Maryland		ent of Health and ate of Death	d Mental Hy	Reg. No.						
	Physici	an	Decedent's Name (First, Middle, Last)	E Booking			2. Date of De Month	Day Year	3. Time of Death					
4	/Medic	al	4a. Fecility Name (If not institution, give st.	E Brown	4b. C	ty, Town, or Location of D	Augus eath	1, 2011 4c. County of Deat	12:10p					
8	Examin Funeral Director		1222 PERRYMAN RD 5. Social Security Number 6. Sex 1		ast birthday) If Un	BERDEEN der 1 Year If Under 24	Hrs. 8. Date of Bi	ay, Year) Co	CO pplace (State or Foreign untry) RIDA					
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits					
	Marylisho	jo.	MARYLAND HARFORD	СО	ABE	RDEEN			1 ☐ Yes ŽXNo					
	or 28	Director	10e. Street and Number		10f.	Zip Code		10g. Citizen of What Co	untry?					
	na 23a must	Funeral	1222 PERRYMAN RD	2. Was Decedent Ever in U.S	S. 13. Was De	21001 cedent of Hispanic Origin specify Cuban, Mexican, P	? (Specify Yes or N	U.S.A. 14 Race - Ame						
736	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show many injury or other traumatic event, I've Medical Examinat must be notified at ance.	by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	l l	specify Cuban, Mexican, P s 2 ⊠X io <i>Specify</i> :	иепо нісап, етс.)	Consider	ACK					
9500-61212	n 72 hor	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's U (Give kind of life. DO NO	Isual Occupation work done during most of T use retired)	working	16b. Kind of Business	Industry					
212	d withi	ome	12th grade	College (1-4or 5+)	HOUSE			N/A						
Maryland	be file ital Hy id othe	Be	17. Father's Name (First, Middle, Last)					e, Maiden Sumame)						
Z	thould id Men marke matic	ဥ	CHARLES FRANKLIN 1 19a. Informant's Name/Relationship (Typ		19b. Mailing Add	ress (Street and Number of	AMILLE NE. or Rural Route Num		Zip Code)					
	alth ar 127 Is		Bertha Copeland/Fr		19 Spes	utia Rd., Al	erdeen, l	Md., 21001						
Baltimore,	Pages 1 a ent of He nt: If Item ry or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Mar (Specify)	moval from State	lace of Disposition emetery, crematory INGTON NA	or other place) Aug	g. 24,201	20c. Location - City or ARLINGTON						
Balti	permit. Departm Importa any inju		21. Signature of Fun ral/S	loeuw	22. Nam WILI	e and Address of Facility IAM C BROWN S PHILA. BLV	COMM FUN	ERAL HOME-HA	ARFORD, P.A.					
			23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a construence of):											
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a constitution	Jence of):	PIOCOC			14 years					
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):									
90928	cate be executed physician and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ										
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	Ideath 3□Ector	ic pregnancy r (specify)		23d. Date of de Month	olivery Day Year					
<u>α</u>	uires that t signed by	by	Part II. Other significant conditions con Lung Cancer			ng cause given in Part I.		tobacco use contribute	o the cause of death? Probably 4 DUnknown					
Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						topsy rformed? prior to death?	utopsy findings available completion of cause of s 2 No					
/ita	ysician: This certificate	Be	25. Was case referred to medical examiner?	o omita l		Othor	of Death (Check onl							
ō	Phys r this ral dir	- To	1 ☐ Yes 2 No	28a. Date of Injury	28b. Time of	DOA 4 Nurs 28c. Injury at Work?		esidence 6 Other (Sp e how injury occurred	ecify)					
ion	Attending Ph ir death. ector: After th by the funeral	ation	1, Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No								
Division	i di di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, fa y)	ctory, office	28f. Location City or	n (Street and Number or I Fown, State)	Rural Route Number,					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	rred at the time, date and ation, in my opinion, death	place, and due to to occurred at the time	ne cause(s) and manner e, date and place, and di	as stated. ue to the cause(s)					
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. License number	١٥	29d. Date signed (Mon	nth, Day, Year)					
			Karen L C	anter MD		D5750	10	08/00	411					
	a		30. Name and address of person who co	mpleted cause of death (Item	Bata Blu	id, Suite A,	Belcamp	, MD 21017	7					
		ate	31. Date filed (Month, Day, Tear)	32. Hegistians Signe	1010	, , , , , , , , , , , , , , , , , , , ,								
	Regist	rar	AUC 0 4 2011 6.	1 1 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 August 11:45 A M Catherine Mildred Brocksmith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel <u>Genesis Eldercare Center</u> Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min. Month, Day Aug 12 19<u>14</u> 212-10-7793 Maryland 96 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🏻 No Carroll Maryland| Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2449 Ridge Road 21157-7448 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Cluney (unk) Luxich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2449 Ridge Rd. Westminster, MD 21157-7448 <u>Donna Wade / Cousin</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Final Journey Crematory 8/5/2011 Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Orset and Death e mer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death
Unknown 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed

Ph sician/ Medical Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

Hygiene. other than '

other t

of Health and Mental H If item 27 is marked of r other traumatic ever

t of Healt : If item ' / or othe

Department of Important; If any injury or

the Medical

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit cate has been signed by the a page 2 should be detached. Hospital or Attending Physician: The law requires that the certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I

Be

မ

Certificate:

Medical

29b. Signature

30. Name and address o

31. Date filed (Month, Day,

Year.

4

P.O. Box 68760

Division of Vital Records,

1 Yes 2 40 3 Probably 4 Unknown 24a. Was an Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Valursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0-ue Cheler, ms 2/6/9

DHMH 17 Rev 7/2009

State

Registrar

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ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20^{rear}1 1:48P M Aug. Katherine Beaver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster 741 David Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 08/09/1935 Director 108-28-0336 75 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Carroll Westminster 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21157 741 David Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3. Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Katherine Reilly Michael J. Gorman 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Broadwater Rd., Arnold MD, 21012 Michelle Beaver-Guttu 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 🔲 Cremation 3 🗔 Removal from State 08/09/2011 4 Donation 5 Other (Specify) Meadow Branch Westminster ervice Licensee 22. Name and Address of Facility Fletcher Funeral Main St. Westminster, MD 21157 23a. Part 1. Enter the di shock, or heart fail ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) use as the burial-transi After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed after death.

Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and 2973 Manchester Rd Manc 32, Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 24816 State of Maryland / Department of Health and Mental Hygiene

ilida Lod Bulla		State Of P 1- For State Registrar		ficate of Death		g. No.					
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last) Cinda	Lou	Bundy	2. Date of Death Month August 2, 2		3. Time of Death 0933 hrs				
		4a. Facility Name (if not institution, give stre		4b. City, Town, or Location		4c. County of Death					
Funeral	4	1 Vista Mobile Drive 5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year If Under	er 24Hrs. 8. Date of Birth	Baltimore Cour					
Director		218-58-3869 _{1 M}		Months Days Hours		Transland					
any	ł	Usual Residence of Decedent 10a. State 10b. County		wn or Location			10d. Inside City Limits				
	þ	Md. Baltimo	ore	Dundalk			1 Yes 2 No				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other thau "natural", or items 23a or 28s-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1 Vista Mobile D	rive	10f. Zip Code 21222	10	g. Citizen of What Count USA	try?				
ath with tems 2.	Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican		14. Race - Americ White, etc.	an Indian, Black,				
E - 1	by Fu	3 Widowed 4 Divorced If Yes	_ Yes 2 ☒ No s, Give Year	1 Yes 2 X No specify:		Specify: Whi	te				
hours		15. Decedent's Education (Specify only hig	hest grade completed) 16 college (1-4 or 5+)	Sa. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b, Kind of Business/In	ndustry ·				
036 ithin 72 ne. r thau '	Completed	12 years	onege (1-4 or 5+)	Nursing		Nursing	Home				
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Joseph Bentley	7	18.Mother	's Name (First, Middle, M Alma VanHos						
MD 21 d 2 should lth and Mer n 27 is man	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S Robert Bundy Son 3100 Whiteway Road, Edgemere, Md. 21										
ages I and nt of Healt it: If item other train		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State crer	ce of Disposition (Name of cernetery, matory or other place) yview Crematory	August 5, 2011	20c. Location - City or T Baltimore,					
Baltin permit. P Departme Importan injury or	3 Widowed 4 Divorced if Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired) 17a Table 1 To Date 2 To Date 3 To Date 3 To										
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Medical. Examiner	1	Immediate Cause (Final disease a. Smc	ke inhalation and the	rmal injuries			Death				
		Sequentially list conditions, b.	o (or as a consequence or).								
	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause	o (or as a consequence of):								
ted Insit	Exan		o (or as a consequence of):								
e execucian and	Medical		ENDED								
8760, ificate be g physici s the buri		23b. Was decedent pregnant in the	c. If yes, outcome of pregnar		c pregnancy	23d. Date of delivery Month D	ay Year				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/	past 12 months? 1 Yes 2 No 9 Unknown 9	Pregnant at time of death Unknown)				
, P.O. Eres that the signed by the be detached	by Ph	3	-	Iting in the underlying cause given in Pa		pacco use contribute to the					
rds, Prequires to been signal be of	ted b	hypertensive atherosclerotic o	ardiovascular disease	e, chronic obstructive pulmona	1 Yes 24a. Was a		ably 4 ✓ Unknown opsy findings available				
cords law requi e has been e 2 should	Completed	disease			autops perforn	y prior to co n <u>ed</u> ? death?	ompletion of cause of				
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical		26.Place of Death	1 Yes 2 (Check only one)	No 1 Yes	2 No				
Nits of all direct	To Be	examiner? 1 ✓ Yes 2 No	I Inpatient 2 Li		Nursing Home 5 F		Scene				
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b		1 Natural 5 Pending	FOUND: Day, Year) F	3b. Time of Injury 28c. Injury at Work OUND: 1 Yes 2 ✓ 929 hrs	. Subject invol	ow injury occurred ved in housefire					
Divis nital or A nus after or eral Direc	To the part of the										
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	one) 2 Medicai Examiner: On ti		death occurred at the time, date and pla or investigation, in my opinion, death oc							
F 3 F 3	Me	29b. Signature and title of certifier	, San Maria	29c. License number	OCME	29d. Date signed (Mon	th, Day, Year)				
		30. Name and address of person who compl	eted ause of death (Item 23	O.C.M.E.		August 3, 2011					
		Theodore M. King, Jr., MD.	Assistant Medical Exa	aminer 900 W. Baltimore Str	eet, Baltimore, MD	21223					
St Regist		31. Date filed (Month, Day, Year) AUG 0 4 2011	32. Registrar's Signature	barkel							
DHMH 17 Rev 1/20 OCME 2006				ORIGINAL							
JOINIL 2000											

11-05708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jamal William Brooks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle Last) Physician/ Jamall Brooks 2. Date of Death 3. Time of Death Month Jamal William Brooks Medical Examiner 1335 hrs July 30, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Johns Hopkins Hospital **Baltimore Funeral** 5. Social Securify Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Country) MD Days 212-02-9427 Director Months Hours 1 X M 2 F 28 Yrs Aug. 27, 1982 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No MD Baltimore n/a permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygien. Department of Health and Mornell Hygien. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once, nights or other traumatic event, the Medical Examiner. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3602 Ravenwood Ave. 21213 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 No specify: Specify: Black \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unemployed n/a 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Brooks Vondia Brim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vondia Brooks 3602 Ravenwood Ave. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, Date orematory or other place)
Oak Lawn Cemetery 1 Burial 2 Cremation 3 Removal from State Aug.5,2011 Balto,Md. 4 Donation 5 Other Specify: Signature of Fundral Service Licenses 22 Name and Address of Facility ruggs Funeral Home 1412 E. Preston St. Balto, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Cardiac Arrhythmia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED 1 per me g918 8-8-11 vt 23a, 27, per me, g919 9-15-11 X UNPENDED the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No e Hospital or Attending Physician: The n 24 hours after death.
e Fuoeral Director: After this certifical letely filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Other4

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Certification:

Medical

examiner? 1 🗸 Yes

27. Manner of Death

28a. Date of Injury (Month, Day, Year) 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

and manner stated

29c. License number O.C.M.E

28c. Injury at Work?

1 Yes 2 No

DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29d. Date signed (Month, Day, Year) July 31, 2011

28f. Location (Street and Number or Rural Route Number, City

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

State Registrar 2 Registrar's Signature

To the Hospital within 24 hours at To the Fuoeral E

Nursing Home 5 Residence 6 Other:

or Town, State)

28d. Describe how injury occurred

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 4 8 1 8

		•	For State Registrar		State of Ma	a ylaria .	•	ate of De		noman my	Reg. No.			
	BI	,	1. Decedent's Nam	e (First, Middle, La	st)					2. Date of De	ath	Voor	3. Time of	Death
	Physicia Medio			Bradby						July	30°	20°1′1	2:15	Ам
	Examin	er	4a. Facility Name (if	f not institution, give	e street and number)				cation of Death		4c.	County of Death		
	<i></i>			Richie H				altimor						
	Funeral Director		5. Social Security N	0674	Sex X M 2 □ F 7. Age	(In yrs. last i	Yrs. Mont		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug 14	195	2 Nev	place (State of York	· Foreign
	how at	ř	Usual Residence of 10a, State	10b. County UI	nk	10c. City, To	own or Location	unk		-		T	10d. Inside Cit	y Limits
	arylar a-f si fied	Director	DC			,,							1 🗌 Yes	2 1 No
	or 28	ρ	10e. Street and Nur	mber			10f.	Zip Code			10g. Citiz	zen of What Cou	ntry?	
	with to 23a ust by	Funeral	1210 M	assachuse	etts Ave NW			20005			U	SA		
	item:	Fun	11. Marital Status		12. Was Decedent Ev	er in U.S.	13. Was De	cedent of Hispa	anic Origin? (Spe Mexican, Puerto	ecify Yes or No-	. 1	14. Race - Ameri		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 X Never Marr 3 ☐ Widowed	ried 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates.	10		s 2 K No S		rilouri, cto.)		Black, White, Specify: b.	lack	
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Maryland	be filk ental ked c	힏		Bradby					Mabel	,	, Maideir O		· ·	
یک	ould ond Me mar		19a. Informant's Na		Type, Print)		19b. Mailing Add	ress (Street and			er. City or T	Town, State, Zip	Code)	
	nd 2 sh ealth au nn 27 is ier trau		Derric	k Bradby	- brother							ida 331		
ore	e 1 ar Tof He Fiter or oth		20a. Method of Disp	position	Removal from State	20b. Place ceme	e of Disposition (a etery, crematory	Name of or other place)		Date	20c. Lo	cation - City or T	own, State	
Ţ.	t. Pag tment rtant rjury c		4 Donation	5 M Other (Spec.	ify)1n state	Atlan	tic Cre		8–9–			n Burnie		
五人 Baltimore,	permit Depar Impor any in		21. Signature of Fir	neral Servide Licer ODA 190 S	Wade, Dire	ctor	Simpi 7090	1c1tysc	Fematic Ltimore	Aller 1	Riner	al Thom	nas A11 21201	en P.A
18		F - 57	23a. Int 1. Enter t	the lisease, or com	plications that caused one cause on each line.	the death. D	o not enter the m	ode of dying, s	such as cardiac	or respiratory a	rrest,	070	Approximate Interval Bet	9
	Physician/		Immediate Cause of disease or condition	(Final		rosta	te car	rer					Onset and D	Death
	Medical		resulting in death)		a. Due to (or as a								G GEO	حر ۵
7	Examiner	Ļ	Sequentially list co	anditions.	b									
0/-	p #	nine	Sequentially list co if any, leading to in cause. Elter U Cause (Disease or	nmediate	Due to (or as a	consequent	ce of):							
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9760	cate l phys	edic			d									
89 ×	certifi nding use as		IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome o							23d. Date of deli	/erv	
200 X	eath e afte d for i	icia	in the past 12	months?	1 Live Birth 2 4 Pregnant at							Month	Day Y	'ear
S.E	the d by the acher	Physician/I	9 Unknown		9 Unknown									
20. P.O.	requires that the death certi been signed by the attendin should be detached for use a		Part II. Other signif	ficant conditions	contributing to death bu	it not resultir	ng in the underlyi	ng cause given	in Part I.			se contribute to		
$\frac{1}{Records}$	quire en si ould l	Completed by								1 🗆	Yes 2	No 3□ Pro	obably 4 ∐ l	Jnknown
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Ze Re	The Jate P	Co								1 🗆 Yes	ormed? 2 No	death?	2 No	
/0/	Physician: The law this certificate has al director, page 2 a	Be	25. Was case referred examiner?		Hospital:			Othori	of Death (Checa		-	a a		
ST.	Physi this or	<u>2</u>	1 Yes 2 2	ZNo h	1 ☐ Inpatie		Outpatient 3 b. Time of	DOA Other:		ome 5 Resi		Other (Specia	y Hospi	(&
Den	Attending Physician: The probability of death. sector: After this certificate I by the funeral director, page	Certificate:	1 Augural 2 Accident	5 Pending	(Month, Day,	Year)	injury M	work?	s 2 🗆 No	280, Describe	now injury	occurred		
Sio	Atten r deal ctor: by the	ij	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injur							Number or Rura	al Route Numb	er,
<i>J</i> Division	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: Atter th completed filled in by the funeral		4 El Hornicide	determined	building, etc.	(Specify)				City or To	wn, State)			
	Hospi 24 hou Funer sted fill	Medical	(Check 2	Medical Exam	vsician: To the best of niner: On the basis of ex	amination an	d/or investigation	in my opinion, o	death occurred a	t the time, date :	and place,	and due to the ca	ause(s) and mai	nner stated.
	o the	Σ	only one) 3 29b. Signature and		rse Practioner: To the b	est of my kn		courred at the tin 29c. License nu		ce, and due to the		and manner as s e signed (Month,		
	- 5 - 0			1	in tell m	D			1788			7-30		
	7		30. Name and addr	ress of person who	completed cause of de		a) (Type, Print)			1				
				Tim F	Polk, MD	6115	falls R	4 # 300	Baltin	nore, M	0 21	209		
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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	ryiand		tificate of D			glerie Reg. No			
			Decedent's Name (First, Middle, La.	st)					2. Date of De	ath		3. Time of	Death
	Physicia Medic	al	Mary L. Carter						Month 8	Dar 2	201	1 7:55	5 A M
	Examin	er	4a. Facility Name (if not institution, give				•	Location of Death			County of Deat	1	
			2631 Guilford 5. Social Security Number 6. S				Baltim If Under 1 Year	ore If Under 24 Hrs.	8. Date of Bir	th	N/A	hplace (State o	or Foreign
-	Funeral Director		217-40-5296	□ IZI =	(In yrs. las: 56	Yrs.	Months Days	Hours Min.	(Month, Da	y Year) 1945	Col	untry) M.D.	Troreign
	br te	_	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation					10d. Inside Ci	ity Limits
	farylar 3a-f sl iffied	Director	MD N/A		Bal	timor	e					1 X Yes	3 2 □ No
	or 28		10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?	
	s 23a	Funeral	2631 Guilford	Ave 2nd F	loor		21218				USA		
	death item ner n		11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of His Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X N If Yes, Give Year or Dates.	lo	1	☐ Yes 2X No	Specify:			Specify: Bl	ack	
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lan	shouls and h is ma		19a. Informant's Name/Relationship (1				,	and Number or Rura					
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Baltimore,	age 1 ant of h		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cer	netery, cren	sition (Name of natory or other plac	e) 0 /6 /	Date 2011		dallst		4D
altir	rmit. Pa spartme sportan sportan sy injur,		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North										1
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- 2	Physician Medical	7	Immediate Cause (Final disease or condition resulting in death)	a	411	1211	101	79				9 1/1	3
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ton Box	e death the attu	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown			Other (specify)	,			Month	Day	Year
P.0.	at the ed by detach		Part II. Other significant conditions	contributing to death bu	t not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco i	use contribute to	the cause of c	death?
S, S	requires that the de been signed by the should be detached	Completed by							1 🗆	Yes 2	□ No 3 □ P	robably 4 💋	nknown
ofte. Record	aw req as bee 2 shoi	plet							24a. Was	psv	prior to	topsy findings completion of c	available cause of
	sician: The law certificate has b irector, page 2 s	Con							perfe 1 \sum Yes	2 N	death?	s 2 🗆 No	
Q_A Vital	ician: sertific ector,	Be	25. Was case referred to edical examiner?	Hospital:	***		Othe	ace of Death (Chec					
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A Duc	nding ath. r: Afte e fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	work	? Yes 2 □ No			,		
MA	r Atte ter des irector ir by th	Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			ne, farm, stre	eet, factory, office		28f. Location (City or To		d Number or Ru	ral Route Numi	ber,
ا ا	spital o	calC	29a. Certifier 1 Certifying Phy	sician: To the best of m	ny knowle	dge death o	occured at the time	date and place, ar	nd due to the ca	use(s) ar	nd manner as st	ated.	
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 Medical Exam	niner: On the basis of example of the basis of example of the basis of	amination a	and/or invest	igation, in my opinic	on, death occurred a	t the time, date	and place	e, and due to the	cause(s) and ma	anner stated.
	Vithi Vithi Com		29b. Signature and title of certifier	911111	121	カ	29c. License	number		29d. Da	ite signed (Moyli	h, Day, Year)	
	•		30. Name and/address et person who	completed cause of dea	ath (Item)	(3a) (Wina "	(right)	20/2	- 1	10	1///		
h			John Havin	2 4/1//	0/	1//	MARR	351,11	Billi	2/	1/2	12/8	7
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	Registra	ir	7001	7									

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Amend Item 3 per med cert G918 8/4/11 dk

Amend Item 1 State of Maryland, 08/04/2011 dhb

Certificate of Death

Reg. No. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Hui Fang Chen O Month Physician/ 2011 FANT CHEN 5:47 -HUIT 14 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 950 Pierpoint Drive Anne Arundel Pasadena 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 □ M 2 🕱 F Months Days Hours Min. 06 09 1937 China Director 74 49 0487 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director 1 Yes 2 K No MD Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1626 Sunshine St. 21061 China 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2. No Specify: Specify: Completed 3 Widowed 4 Divorced Chinese permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jones. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Preschool Education Kindergarden Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Zhan Chen Kun Li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pierpoint Dr 21122 Mei Brown - Daughter Pasadena. MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 7/15/11 Bavview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer > ervice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home PA 169 Riviera Drive 21122 Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions This to forms a nonscouence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death been signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No certificate Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after weare...

To the Funeral Director: After of many filled in by the funer Certificate: Home injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signatur 29c. License number 29d. Date signed (Month. Day, Year) 2 man ause of death (Item 23a) (Type, Print) 30. Name and address of person de URN 31. Date filed (Month, Day, Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25&26 Per Phy G918 8/04/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 24821 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JOSE TRINIDAD VILLATORO COLINDRES 30 2011 11:10 a[™] Ju1v Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE 2013 RITTENHOUSE ST HYATTSVILLE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, 1 x M 2 - F **Director** Yrs 9 227**-**91-8872 59 ociedad Morazar June Usual Residence of Decedent show 10b. County 10a. State mit. Page 1 and 2 should be filed within 72 hours after death with the Manyland asstreet of Health and Mental Hygiene. Asstrant of Health and Mental Hygiene. Outlant: I filem 27 is marked other than "natural", or items 23a or 28a-f sho outlant: If them 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD HYATTSVILL PRINCE GEORGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2013 RITTENHOUSE ST 20782 SALVADOR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 ✓ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed SALVADORIAN WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION LABOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ VISITACION VILLATORO CATALINA COLINDRES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERICK RAFAEL BLANCO (Son in Law)2013 RITTENHOUSE ST HYATTSVILLE, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Page 1 g Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, General de Sociedad 08/9/11 Morazan, El Salvador 22. Name and Address of FacilitySanta Cruz Funeral Services, Inc 21. Signature of Funeral Service Licenses 600 Kennedy ST, NW:Washington, DC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Jancreas Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician as the burial-1 Physician/Medical P.O. Box 68760 attending properties for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death / the a signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy performed 2 No 1 Yes Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 🗆 Nursing Home 5 Residence 6 🗀 Other (Specify) 2**XX**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accider 5 Pending work 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director. / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SNO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green way CT Dr Green belt HD

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20

for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 7:46 AM ELIZABETH MARGARET CHASE August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCK SPRING VILLAGE Hil HARFORD FOREST If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Hours Min Feb 9 Day, Marviand Director 215-18-8581 90 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State within 72 hours after death with the Maryland Director must be notified 1 Yes 2 X No Forest Hill <u>Maryland</u> Harford 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number items 23a Funeral United States 313 Donald Circle 21050 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. ö 1 Never Married 2 Married þ Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: "natural", 3 X Widowed 4 Divorced White Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygliene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Elizabeth Julia Wenderoth Charles Christopher Kahler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Donald Circle Forest Hill, MD 21050 Josephine J. Welsh / Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State Final Journey Crematory 8/4/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death brovas celar Immediate Cause (Final Physician/ ore MOA disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list non-itions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death ed by the a P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Asst Living 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 208 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Campbell 2011 04:10 AM Mildred August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Co. 1031 Thomas Road Glen Burnie If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 TTA **Funeral** 03/24/1927 VA 230-28-8260 84 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director MD Anne Arundel Glen Burnie 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r Funeral tems 23a USA 21060 1031 Thomas Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces ō 1 Never Married 2XXMarried Yes 2XXNo ģ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Denta1 Dental Assistant event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H Department of Health and Menta Important: If item 27 is marked any injury or other thems ၉ Birtie Phillips Jasper Henry King 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 1031 Thomas Road Mr. Charles G. Campbell, Sr. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 8/8/2011 Marriottsville, MD Crest Lawn Memorial 4 Donation 5 Other (Specify) 21. Signat (b) Funer 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, on on shock, or heart failure. List only Approximate Interval Between Immediate Cause (Final Physician/ KENAL CHRONIC cers disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** YPERTR NSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events -tran and resulting in death) Last Due to (or as a consequence of): burialphysician sthe burial Physician/Medical certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ hed by the attent detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTRAY DISRASZ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Hesidence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner & Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) RITCHIE INY PASADENA

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 2. Date of Death 3. Time of Death Physician/ 7:40 AM August , 201 Medical Rock Glen Nursing to or Location of Death 4c. County of Death Examiner Home hmore (In yrs. last birthday) 93 Yrs. **Funeral** . Date of Birth 219-01-255 O'Mory, Day Country) Director 10a. State 10c. City, Town or Location

Baltimore 10d. Inside City Limits **Funeral Director** ems 23a or 28a-f sh r must be notified a 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 21229 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. "natural", or iter Important: If item Z7 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. once, Black, White, etc.

Specify: Black 1 Never Married 2 Married 1 Yes 2 No Completed by Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work dong Yuring most of working
(C) DO NOT use retired)

16a. Decedent's Usual Occupation
(G) DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be Keels ase 19al Informant's Name/Relationship (Type, Probaughter) 19b. Mailing Address (Stre Jordan Baltimore. 20b. Place of Disposition (Name of temetry, crematory or other place)

Arburus Memoria 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signat re of Funeral Service Licensee Vaughn C. Preere 5151 Balto. Nat'l Fik
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Silerotic Learl- desecor Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Regrientially list nunditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year signed by the at Yes 2 No 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by erature Joint 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 🗌 Yes 2 🔛 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred injury 1 A Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 121649 AUGUST 2, 2011 Parkare-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wekens Ave. Baltimeri 55 31. Date filed (Month, Day, Year) State AUG 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24825 amend item 5 per fh g918 8-8-11 vt. State of Maryland / Department of Health and Mental Hygiene

		for State Registrar	Otate of IV	iai yiai ia 7	•	ificate of L		a Wichtairi	Reg. I					
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Exami	ner	4a. Facility Name (if not institution Washington Adv	· -	ta1		4b. City, Town, or Takoma		eath	- 1	4c. County of Death Montgomery				
Funeral Director		5. Social Security Number 428–90–3558	6. Sex 7. Ag	ge (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days			Birth	9. Birt	hplace (State or Foreign intry) MS			
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the M or 28 e noti	ij	10e. Street and Number		Washiin	gcon	10f. Zip Code			10g.	Citizen of What Co				
n with 1s 23a nust b	Funeral Director	2223 13th Stre	eet, NW			20009			U	U.S.A.				
r deati r iten iner n		11. Marital Status 1 ☒ Never Married 2 ☐ Mari	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	D-	14. Race - Amer Black, White				
036 s after ral", o	ed by	3 ☐ Widowed 4 ☐ Divorced	If Ven Ohio	l No	1 !	☐ Yes 2 🛛 No	Specify:			Specify: Bla	ack			
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ylar Id be f Menta arked attic ev	욘	Eugene Davis,	Sr.				Ze1da	Lorraine	e Th	omas				
Mar shou h and 7 is m		19a. Informant's Name/Relationsh			_					or Town, State, Zip				
and 2 Health tem 2		Lorraine Johnse	on (Sister)			Mission tion (Name of	66 Apt.	#202, V		sburg, MS Location - City or				
		1 🕅 Burial 2 □ Cremation 4 □ Conation 5 □ Other (S	3 ☐ Removal from State	cemete	ery, crema	tory or other place. Cemeter		10-2011	1	icksburg				
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Fineral Service L	insee		22. D i	Name and Addres	sley Fu	meral Ho Vicksburg	ome o M	s 39180				
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	the death. Do						5 37200	Approximate Interval Between			
Physician	76 6	Immediate Cause (Final disease or condition	2	Se	\$	Sis				1	Onset and Death			
Medical Examiner		resulting in death)	Due to (or as	a consequence	7.1	/.	- 4	1	,					
	Jer	Sequentially list conditions, if any leading to in recitate cause. Enter Underlying	b. Due to (or as	a consequence	h'v	e ni	- 81	~	۷					
ansit a	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c											
flicate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):									
6 / 6U ificate b ig physia as the b	Medical		d											
certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		h 3∏:	Ectopic pregnanc	:v			23d. Date of deli	ivery			
he death of the death of the atternoon of the atternoon of the atternoon of the atternoon of the the the the the the the the the the	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	,			Month	Day Year			
that the	by P	Part II. Other significant condition	ns contributing to death b	out not resulting	in the und	derlying cause giv	ven in Part I.				the cause of death?			
rdS,								1 [] Yes	2 🗖 🗚 6 3 🗆 Pr	obably 4 🗆 Unknown			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed							_ per	s an opsy formed? s 2	prior to death?	opsy findings available completion of cause of			
clan: clan: ertifica	Be (25. Was case referred to medical examiner?	Hospital:				ace of Death (Ch			10 10				
Physion this corral direction	<u>ان</u>	1 Yes 2 No	1 ☑ Inpati	ent 2 ER/Ou	utpatient Time of		4 ☐ Nursing	·		6 Other (Speci	fy)			
on or nding Pl ath. : After the	cate	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	g (Month, Da		injury	28c. Injury work M 1 🗆		28d. Describe	how inji	ury occurred				
IVISION or Attendir after death. Director: Af	Certificate:	3 Suicide 6 Could in 4 Homicide determine	not be		ırm, stree	t, factory, office		28f. Location City or To		and Number or Run te)	al Route Number,			
Lospita A hours Tuneral Red filled	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of xaminer: On the basis of e	my knowledge, xamination and/o	death oc	cured at the time,	, date and place	, and due to the o	cause(s)	and manner as state	ted.			
o the lithin 2 or the lomple		only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my know	ath occurred at the	e time, date and	place, and due to	the cause	e(s) and manner as	stated.				
F>Fŏ		255. OGINATION OF COLUMN	0					υ		Date signed (Month) $Z - 3/-$				
2		30. Name and address of person v	who completed cause of d	eath (Item 23a) (Type, Prin	11) 831	1.4 m	V W S My	4	7-31-	al			
Sta	te	31. Date filed (Month, Day, Year)	100	ar's Signature		'ک	1100	ar T	120	20 90	<u>د</u>			
Registr														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per me, g918,08/04/2011dhb
State of Maryland Department of Health and Mental Hygiene

1 - For State Amend Item 25 per me, g918,08/02/2011dhb
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Thomas M. Downs Physician/ 110 2011 JUL Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year)
June 30.1960 **XX** M 2 □ F Months Days Hours Min. Country) 220-82-9288 51 **Director** MD Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Director MD N/A 1 XXYes 2 \(\subseteq No **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 3623 Elm Avenue 21211 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Ş Q 1 Never Married 2 Married ild be filed within 72 hours after i Mental Hygiene. 1 Tes 2 No Specify. Specify: White Completed 3 Widowed 4 Trivorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Master Plumber Plumber & Fitters Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bennett Downs Goldie Watson permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goldie Downs (Mother) Balto, MD 21211 3623 Elm Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LakeView Memorial Park 7/18/11 Svkesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 27211 Part 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Severe Cardiac Conduction Defect Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ TUTAL MOXIC Drain Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to lor as a consequence of if any leading to immedicause. Enter Underlying EXAMINER attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION APPROVED D Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? signed by the atte Month Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: မြ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

that the death certificate be executed Box 68760 P.O. Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check

29b. Signature and title of certifier

Sreenath

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121/anki

01

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) July 13, 2011

Baltimore, mi)

29c. License number

niversity

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Mary Katherine Du Bois July 31 2:40 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, 18) **July** 18 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2 🗓 F Months Hours Yrs **Director** 579-48-5752 78 July. Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 X No Maryland | Montgomery Washington Grove 10e. Street and Number 10g. Citizen of What Country? must be Funeral items 23a 119 Maple Avenue 20880 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status al Hygiene. Jother than "natural", or iter vent, the Medical Examiner 14. Race - American Indian, D UA 015 Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked on မ Maurice Crass Mary Katherine Kroeger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Theodore F. Crass/Nephew Gracie Road, Lynn, Massachusetts 01904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State August 4, injury or Department of Important: If any injury or once. Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home, R. M01530 300 W. Montgomery Ave., Rockville, Signature of Funeral Service Haran M. Rockville, Inc. e, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ BOWEL ISCHEMIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CLOSTRIDIUM DIFFICILE Sequentially list conditions, Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Examir physician and s the burial-transit Cause (Disease or linjury that initiated events RESPIRATORY FAILURE Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death the Unknown detached 9 Unknown P.O. signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? 2 No Yes 2 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 X No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after ueau... he Funeral Director. After th maleted filled in by the funeral funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 10 7117 ress of person who completed cause of death (Item 23a) (Type, Print) D.O. 9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND JULIE DANG 32. Registrar's Sanat 31. Date filed (Month, Day, Year) State AUG 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are-Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Medical 4a, Facility Name (if not institution, give street and number) Balkmun Examiner 4b. City, Town, or Location of Death County of Death 405 a/finunci If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗹 Hours Country) Director 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1

Yes 2 □ No more 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? Funeral items 23a permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other transmatic contents. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) most of working Elementary Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) (Daughtu) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) f Funeral Service Licens Signatu Name and Address of Home, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, POXIA disease or condition resulting in death) Medical Due to (or as a sequence of) Examiner tracheastury Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 mg ths? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death the signed by the a 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 Onknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural injury 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 West 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death nt's Name (First, Middle, Last) Date of Deat 3. Time of Death Physician/ Month 7:10 A M 201 Medical and number) City, Town, or Location of Death Examiner ; Baltimore atonsville 6. Sex 7. Age (In yrs. **35** If Under 24 Hrs. 8, Date of Birth vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗸 F Hours Country) Director 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a State 10h. County 10d. Inside City Limits Funeral Director Limore 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Monastery 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide 2 other traumatic Department of Health ar Important: If item 27 is any injury or other trau Baltimore, d of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State Iew 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** quartially list condition Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the b 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) ess of person who completed cause of death (Item 23a) (Type, Print) Steros Ceroninile MD 21228 31. Date filed (Month, Day, Year, State Registrar

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Clement

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24830 State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Lamont Graham 2029 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital N/A Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 214-50-9572 1 🛛 M 2 🗆 F Months 3/5/1949 Country) Hours Min. 62 **Director** MDUsual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1047 Cameron Road 21212 USA Page 1 and 2 should be filed within 72 hours after death vector to Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

Yes 2

No
If Yes, Give Black White etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Stationary Engineer llth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosaling Jones <u>Andrew Graham</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Graham - Wife 1047 Cameron Rd. Baltimore, MD 21212 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. Ave. Baltimore, MD 21202 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ ACUTE Medical resulting in death) Due to (or as a consequence of) Examiner DIOVASCULAR ATHEROSCL S quartially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ DOA Director: After this 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Vatural iniury 5 Pending 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) NO 30. Name and address of person who cause of death (Item 23a) (Type, Print)

State Registrar KERITH

LOCH RAVEN

BUND

BALTIMORE, NO 212 39

5601

32. Registrar's Signature

com eter

Please Type of Print in Black Indeliale Ink. Ensure All Copies Are Legible. 20 | 2483 | State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Registrar ent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day July 27, 2011 **Medical Examiner** asser 2247 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months 220-49-7252 Days **Director** Country) 2 Usual Residence of Decedent 10a. State 10d. Inside City Limits County vn or Location 1 Yes 2 2 28a-f show toward with the Maryland 10f. Zip Code 10e. Street end N 10g. Citizen of What Country Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 4 Divorced If Yes, Give Yaar 1 Yes 2 No specify: É 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/ Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 11th len 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maide Surname) umatic event, t istine Be ship (Type, Print) 19b. Mailing Address 2 (Str 4Pの1045 8 lother ent of Health an int: If item 27 olumbia and 20a. Method of Disposition 20b Place of Disposition (Name of cemete Elkridge MD Baltimore, MD 1 Burial 2 Cremation 3 Removal from State Green at Mountain place) Department or Important: 1 injury or oth Meadowridge Baltimore Donation 5 Other Specify ure of Funeral Service Lice Services Tree and Alicess of Cilliforder 5151 Balto. Pilce Nat 23a. Pert I. Entek the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and (Medical Death a Multiple Sharp Force Injuries Immediate Ceuse (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit law requires that the death certificate be executed Physician/Medical UNPENDED $^{\mathsf{AMENDED}}$ #20b,c,perFH,G918,8/16/2011,WS ned by the attending physician detached for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown of Vital Records, P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown page 2 should be Completed has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) director, Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 2 No ၉ 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject stabbed and cut 1 Natural FOUND Division 5 Pending 1 Yes 2 ✔ No by the hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 8710 Airybrink Lane, Columbia, MD determined (Specify) Residence 4 V Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 28, 2011 horaxel 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 4 32. Registrar's Signatur State 201 Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depar	tment of Health and I ficate of Death	Mental Hy	giene 2 n		24832		
			Registrar Certii 1. Decedent's Name (First, Middle, Last)	ncate of Death	0.0-140	Reg. No.		3. Time of Death		
Phys M	sicia: ledic		Antoinette Johnson		0.8 Date of De	02 2	ďŤ1	6:15A M		
Exa	amin	er	4a. Facility Name (if not institution, give street and number) Future Care Homewood	b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Fune Direc				If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir 03/11					
			Usual Residence of Decedent		103/11/	7 1 9 0 1				
farylan 3a-f sh	uried a	Funeral Director		Baltimore			110	0d. Inside City Limits 1 Yes 2 □ No		
h the N	pe no	al Dir		10f. Zip Code		10g. Citizen of V	What Coun	try?		
ath with	must	uner	2408 Loyola Northway Apt. T-2	21215	asifu Vas av Na		S.A			
fter de	amine	by F	1 ★ Never Married 2 Married Armed Forces?	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	Rican, etc.)	2.40	e - America k, White, e			
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Maryland 21215-0036 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 show	anc ev	ပ	Charles Preston Johnson			ia Tall	,			
ore, Marylal and 2 should be of Health and Ment fitem 27 is marked	traum traum			Address (Street and Number or Run						
and and	ame		20a. Method of Disposition 20b. Place of Disposition	Loyola Northwa	ay Apt.	20c. Location -				
Saltimore, bermit. Page 1 and Department of Heal mportant: If item;	io din			cory or other place) Cemetery 08/0	8/11	Baltim	ore,	MD		
Baltimor permit. Page 1 Department of I Important: If it	once.		21. Signature of Funeral Service Licensee \$\frac{\frac{1}{3}\text{ON}}{214}\$	rean Adness of Brown 10 N. Fulton A	Jr. Fu	neral Baltimo	Home re,	PA MD 21217		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory are	rest,		Approximate Interval Between		
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pe tisi		mine	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury							
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certifica anding pluse as t		M/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date	e of deliver	rv		
he death or y the atter ched for u		Physician/Me	1	ther (specify)		Mor		Day Year		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		à	Part II. Other significant conditions contributing to death but not resulting in the under Diality Hutur Lim	erlying cause given in Part I.		obacco use contri Yes 2 \(\square\) No		e cause of death?		
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II OI VILAII NECC ding Physician: The law h. After this certificate has funeral director, page 2:	(25. Was case referred to medical	26. Place of Death (Check	1 \(\text{Yes}		Yes 2	2 🗆 No		
hysician: this certifical	į,	으	examiner? 1 Yes 2 W No Hospital: 1 Inpatient 2 ER/Outpatient	Other: 4 Nursing Ho		lence 6 Othe	r (Specify)			
nding Plath.: After the funeral	ŀ	cate	27. Man er of Death 1 V Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe h	ow injury occurre	d			
al or Attendir s after death. Il Director: Af		Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		28f. Location (S City or Tow	itreet and Number n, State)	r or Rural F	Route Number,		
Hospita 24 hours Funeral		edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence (Check 2 Medical Examiner: On the basis of examination and/or investigate	ion, in my opinion, death occurred at	the time, date a	nd place, and due	to the caus	se(s) and manner stated.		
To the vithin To the comple	1		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deat 29b. Signature and title of certifier	h occurred at the time, date and place 29c. License number	e, and due to the	e cause(s) and mar 29d. Date signed	nner as stat	ay, Year)		
) Jsotto	117537		8.4	. /1			
\			29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print, DARLHAN S, SALUM 6621 Ref. Sex. 31. Date filed (Month, Day, Year) AUG 0 4 2011 AUG 0 4 2011	stown RD, Na	ltimore	MD 2	12/	5		
Regi	State istrar		AUG 0 4 2011 Server 32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24833 For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) :55 Physician/ 4c. County of Death Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) Examiner More ome g. Birthplace (State or Foreign 8. Date of Birth (Month, Day, If Under 24 Hrs. Country) MD If Unde 7. Age (In yrs. last birthday) Min. Months Days Hours Funeral 1 M 2 F Yrs Director Isual Residence of Decedent 10d. Inside City Limits Town or Location 10c. City, iral", or items 23a or 28a-f show Examiner must be notified at 10b. County State filed within 72 hours after death with the Maryland Director 1 Nes 2 No 6 Ce 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 ac 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Nother's Name (First, Middle, Maiden Şurname, Be 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 's Name/Relationship (Type, Print) Daughter) 19a, Informa 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) And Address of Facility ASS Funeral Home, Pet. 21. Signature of Funeral Service Licens Balto North 23a. Par 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence o Examiner Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown the q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4 hknown ğ pe Completed 24b. Were autopsy findings available prior to completion of cause of death? peen 24a, Was an autopsy performed? has 1 Yes 2 this certificate 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, To Be Other: 4 Adrsing Home 5 Residence 6 Other (Specify) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death. I Director: After the Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending Natural Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) certifier 29b. Signature 0076 of death (Item 23a) (Type, Print) JOU 2

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 24834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ July 31. 3:20 P M Carroll Cecil Medical Jessee 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Good Samaritan Assisted Living Silver Spring Social Security Number 8. Date of Birth Oct. 27 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Year)19<u>31</u> 1 XM 2 □ F Months Virginia Director 229-38-2885 79 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Pepartment of Health and Mental Hygiene.

Important: (frem 2') is marked other than "natura"

any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No VA Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10100 Wimbledon Court 20110 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. ò 1 Never Married 2 Married White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Manassas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ellis Jessee Lucy Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara M. Jessee/Wife 10100 Wimbledon Ct., Manassas, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 8-3-2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature | f Funeral Service Licenses 22. Name and Address of Facility Pierce Funeral Home aller 9609 Center Street, Manassas, Virginia 20110 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Pnysician/ Alzheimer's dementia 8 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown ed by the a detached f 9 Unknown P.O. is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy To the Hospital or Attending Physician: The certificate Yes 2 X No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ပ 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Home this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 🛭 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 8/3/2011 D35996 30. Name and address of person wito mpleted cause of death (Item 23a) (Type, Print) Linda M. Burrell, MD 7730 University Blvd #400, Wheaton, MD 20902

State Registrar AUG 0 4 2011

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Day 2011 August 12:37 P M Christine Claire Kaufmann 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 523 Shipley Rd. Linthicum 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Days Hours Months April 1 (Month, Day, 1 (6, 1951) MaryTand Vrs 60 220-60-9306 Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🏹 No Maryland | Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21090 523 Shipley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna M. Backoff Frederick J. Kaufmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 374 Centerhill Ave, Linthicum, MD 21090 <u>Patricia Lentz</u> 20a. Method of Disposition 20h. Place of Disposition (Name of Aug Date 4 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 $\overline{\mathbf{X}}$ Cremation 3 \square Removal from State 2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral ? rvice 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final GASTRULATISTNA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury

Macertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

physician and s the burial-trans certificate be P.O. Box 68760 attending ph signed by the a d be detached f To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Furneral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records,

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at

within 72 hours after death

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n and Mental Hygien is marked other t

Department of Health and Ment Important: If item 27 is marke any injury or other traumatic

Physician/

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Certificate:

Examiner

the

Maryland 21215-0036

Baltimore,

To the Hospital o within 24 hours aff To the Funeral Di Medical State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

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& CAMP MRADITED : LINTIMO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SHAVIANS

Accident

Suicide

4 - Homicide

only one) 29b. Signature and title of certification

29a. Certifier (Check

> D. 1 32. Registra's Signa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 3. Time of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LE Month 67 2011 D Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner Bellimore Secous Social Security Number If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 💢 F (Month, Day, Country 85 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 740 Poplar Grove St. Apt. 12-E 21216 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items: amy injury or other traumatic event, the Medical Examiner munone. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Katzenberg Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress 10th N/A Brothers, INC Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oscar Sneed Hannah Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Fordleigh Rd. Apt. D Balto., MD 21215 <u> Karen Lyle - Granddaughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest 8/8/2011 OwingsMills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. Ave. Baltimore, MD 21202 Brandon Melan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final P Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions ne Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury transit. Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Records, P.O. Box 68760 ast been signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Day 5 Other (specify) 9 Unknown should be detached Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has page 2 performed 1 Yes 2 No ours after death.

eral Director: After this certificate filled in by the funeral director, pag Q 0 Times **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after a Funeral Direc determined Medical To Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}2011 July 30. 10:30 P M Lester Lewis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George 3001 Queens Chapel Road Hyattsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Virginia 1 5x M 2 🗆 F 1949 Director 61 227-66-3747 Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🖾 No MD Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 20782 3001 Queens Chapel Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced r arked other than "natur after event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 sho ld he fil ment of Health and Mental ပ Evelyn Mae Carter Lester Lewis, Sr. 19a. Informant's Name/Relationship (Type, Print) anc is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 13014 Salford Terrace, Upper Marlboro, MD 20772 Annette D. Lewis/Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place) Branch Fork Baptist Church 9 1 🛣 Burial 2 □ Cremation 3 □ Removal from State injury (4 ☐ Donation 5 ☐ Other (Specify) 8/6/2011 Spotsylvania, VA 22. Name and Address of Facility A.L. Bennett & Son Funeral any inj once, e of Funeral Service Licensee Home, Inc., 200 Butternut Dr., Fredericksburg, VA art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Atheroscleptic Physician/ Coronary disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause (Disease or linjury pe I Harinsulin dependent g physician and s the burial-trans labetres that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Seconant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year certificate has been signed by the a rector, page 2 should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No s after death. 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie License numbe 29d. Date signed (Month, Day, Year) D005033 H. W ¥1115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN 14310 Old marlboro MD Soro 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ S. Lemon 1:15 PM Lisa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Yea Country) 214-92-5929 42 Director 196 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location event, the Medical Examiner must be notified at Director Baltimore Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral USA items 23a 21211 331 W. Lorraine Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working American Red Cross permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lab Tech Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) James Kelley ပ Joyce Hargrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
331 W. Lorraine Ave. Balto, Md. 21211 Gregory Lemon (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, Western Star Cem. Aug.8,201 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Financial Service Lice Calvin B. Scruggs Funeral Home St. Balto.Md 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 horurs after death.

To the Furnaral Directors. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnel. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably W Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed 1 Yes 2 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ၉ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title. er certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0066919 119011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Mary University Parkway mcciosk 201 East WD

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 4 2011

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard Leo Lanahan Physician/ 401 PM Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MYUKE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye v Number g. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Months Days Hours Country)
Marvland 220-68-2032 **Director** 1957 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 X No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Stout Run Court 21228 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene.
ad other the College (1-4 or 5+) Elementary/Seconday (0-12) Auto Mechanic/Service Advisor Automobile Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ William J. Lanahan, Sr. Velda A. Dooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Lanahan 17 Stout Run Court; Catonsville, MD 21228 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 8/3/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ NEARCTION MYDRARDIAL MKGTUN disease or condition a. Medical resulting in death) Due to (or as a consequence of): Examiner JAKIOWN WARING TO Sequentially list conditions in any, leading to in mediate cause. Enter Underlying Examine Due to (or as a nonsequence of Cause (Disease or linjury that initiated events resulting in death) Last UNKNOWN HYPERLIPIDEMIA attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No certificate has been signed by the atte irector, page 2 should be detached for Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARK

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DALTIMOPE

2011

21229

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louis 9:49 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lallstones Worthwest Hospital If Under 1 Year If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours April 17. 1 ★ M 2 □ F 212-01-4022 **Director** Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🙀 No MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1906 Englewood Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) d Mental Hygiene. marked other than College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry H. Lucas Ella Speiker and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Leola Lucas 1906 Englewood Avenue; Woodlawn, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cemetery 7/30/2011 Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signature of numeral Service Licen 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thous after death.

Funeral Director: After this certificate has been signed by the attending physicial end filled in by the funeral director, page 2 should be detached for use as the burn and the funeral director, page 2 should be detached for use as the burn and the funeral director, page 2 should be detached for use as the burn and the funeral director, page 2 should be detached for use as the burn and the funeral director, page 2 should be detached for use as the burn and the funeral director, page 2 should be detached for use as the burn and the funeral director page 2 should be detached for use and the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ျဉ 1 ☐ Inpatient 2 ► FR/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 🗆 No 1 Tyes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral E Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0071045 8+ and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Pandallstong, MD Hospital State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24841 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2ŎT1 August 6:15 A M Rosie Ann Larmore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3611 Adams Drive Silver Spring 9. Birthplace (State or Foreign Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Ye January 19 1 □ M 2 🗓 F Months Hours 82 218-24-6285 Yrs Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code should be filed within terver.

I and Mertal Hygiene.

I is marked other than "natural", or items 23a or aric event, the Medical Examiner must be recover. 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 3611 Adams Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker County Schools 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ 127 is marker er traumatic e Bessie Effie Merson John Charles Boswell Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Adams Drive, Silver Spring, Maryland 20902 Linda A. Larmore /Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date August 8, __2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Supplette Bournes M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ Lewy Body Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the SB use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No for Month Dav Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Type II Diabetes, Coronary Artery Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Was an has page 2 performed? Yes 2 X No certificate 2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 Yes 2 No 2 Accident the Investigation 24 hours after deatl Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

AUG 0 4 2011

Neelam B. Shah, M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

D51724

10810 Connecticut Avenue, Kensington, Maryland 20895

29d. Date signed (Month, Day, Year) August 2, 2011

11-05499 Tracie Logan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011 24842

	1- For State Registrar	,	Certifica	ate of l	Death				g. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Midd							Date of Deat Month July 23, 20	Day Yea	3. Time of Death 1529 hrs
	4a. Facility Name (if not instituti Mercy Hospital	on, give street and number)	46	o. City, Town, o Baltimore		4c. County o			
Funeral Director	5. Social Security Number	6. Sex 7. As	ge (In yrs. last birtl 43	hday) Yrs.	If Under 1 Yes	8. Date of Birl		9. Birthplace (State or Foreign Country) MARYLAND		
faryland 28a-f show any Lat once. ector	Usual Residence of Decedent 10a. State 10b. County MD N N / A		10c. City, Town or Location BALTIMORE							10d. Inside City Limits 1 XXes 2 No
th the Maryland 23s or 28s-f sho notified at once.	10e. Street and Number 2839 WOODBROO	OK AVE.		10f. Zip Code 21217					og. Citizen of Wh	at Country?
fter death wi !", or items er must be / Funers	11. Marital Status 1 X Never Married 2 N 3 Widowed 4 Di	Married 12. Was Deceden Armed Forces 1 Yes 2 ivorced If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, et						- American Indian, Black, , etc. BLACK
5-0036 ed within 72 hours al tygiene. other than "natural the Medical Examin Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12 -11-		5+)	during most of working life. DO NOT use retired)						siness/Industry
nore, MD 21215-0036 sges I and 2 should be filed within 7 nt of Health and Mental Hygiene. t: If item 27 is marked other than other fraumatic event, the Medical	CLARENCE N. I	LOGAN			0.01 (22-12-22-)	JA	ACQUE	LINE M		
MD 21 d 2 should th and Me n 27 is ma tumatic ev	19a. Informant's Name/Relation PATRICIA WELO									n, State, Zip Code) RYLAND 21217
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 injury or other fraumingury or other fr	20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal from S	tate cremate	ory or othe		1		Date		City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other 5		METRO						1	ORE, MARYLAND
	Youth	V. Trus								MARYLAND 2121 Approximate Interval
Physician Medical Examiner	23a. at I. Enter the disease, of a ure. List only one caus Immediate Cause (Final diseas or condition resulting in death)		ine)and	toxic coca:	ation(N ine use	lethac	lone,	Tramado	01,	Between Onset and Death
Jer Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of).							
red Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	sequence of):							
execul an and al - tra		d AMENDED 23.	a,27,28a	-f,pe	r me,g	918 8-	-11-1	l sm		
by the attending physiciched for use as the burn Physiciched for use as the burn Physician/Med		the 1 Live birth 4 Pregnant a	ome of pregnancy at time of death		Il death 3 er (Specify)	Ectopio	c pregnan	су	23d. Date of Month	delivery Day Year
P.O. E es that the e igned by the detached	•	itions contributing to dea	th but not resulting	g in the un	derlying cause	given in Pa	art I.			bute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician.		<u> </u>				-		1 Yes	rmed?	Vere autopsy findings available prior to completion of cause of leath? Yes 2 No
Vital Recipysician: The this certificate I director, page	examiner?	F-1	ient 2 🗹 ER/O	utpatient		Other			Residence 6	Other:
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page ledical Certification: To Be Corr	27. Manner of Death 1 Natural 5 Per 2 Accident Inv	28a. Date of In (Month, Day) nding fd 7-2	Year) 3-11 fd	Time of Inj	hrs 1	ury at Work	No [Jnknown		
Divis pital or A ours after eral Dire filled in b	3 Suicide 6 X Co	uld not be	Injury - At home, fa Iercy Hos			building, et	ic.		Street and Numb State)Balti	er or Rural Route Number, City more, Md.
To the Hospital within 24 hours. To the Funeral completely filled		Physiclan: To the best of r caminer:On the basis of ex and manner stated	amination and/or i	ath occurre investigation	ed at the time, on, in my opinion	date and pla on, death oc	ace, and o courred at	lue to the caus the time, date	se(s) and manner and place, and c	as stated. lue to the cause(s)
H SH S	29b. Signature and title of certification					.M.E.			July 24, 20	ed (Month, Day, Year)
	30. Name and address of person Pameta E. Southall,	· ·		r 900	W. Baltimo	re Street	t, Baltim	nore, MD 2	1223	
State Registra	31. Date filed (Month, Day, Year	r) 2. Registr	ar's Signature	he al						
DHMH 17 Rev 1/2001	V 12	Contract of the contract of th	OF	RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Items 23aPtI,25,28a,d per me, 9918,08/18/2011dnb Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ 2011 6:30 ont omen P Wayst Medical Facility Name (if not institution, give sty 4b. City, To vn, or Location of Death 4c. County of Death Examiner Dre 7. Age (In yrs. last birthday If Unde 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Country a 0 Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 □ No more 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ms 23a or must be n ö Funeral 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Deceder Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ဂ္ဂ One OM 19a. Informant's Name/Relationship (Type, Print) 1 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place MILLS 4 ☐ Donation 5 ☐ Other (Specify) 002 FOCE 21. Signature of Funeral Service Licens Home 222 Th tasses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILATERAL Physician/ PITEUMINIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner A57100:14N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed the burial-transit EXAMINER ON APPROVED BY ME that initiated events resulting in death) Last and Due to (or as a consequence of): CERTIFICATI attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Day Month 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy perform this certificate Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ADDITED LIV. ဂ္ 1 Yes 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Medical Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director; After (Month, Day, Year) injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 1.1. Accident Investigation completed filled in by the 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertliying Nurse Fractioners Tellin best of my included a state of the figure of the (Check within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2652 3/20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/215 777 E BALTIMIRE NID 115m 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ James S. McKinley 30 July12:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1208 Broadwood Drive Rockville Montgomery 5. Social Security Number If Under 1 Year If Under Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🖳 M 2 🗆 F 208-22-7638 Months Hours July Day Year 1915 96 Georgia **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1X Yes 2 ☐ No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Broadwood Drive 20851 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1933 Black, White, etc. by 1 Never Married 2 1 Married to 1960 1 Yes 2 No Specify: If Yes, Give 3 - Widowed 4 - Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Agent Armed Forces Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Grover McKinley Frances Josie Sentell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma McKinley - Wife 1208 Broadwood Drive Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ABuria 🔫 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Odd Fellows Cemetery 8-3-11 Stoystown, PA 21. Sign Ture of Fureral Service Licens 22. Name and Address of Facility Deaner Funeral Home 133 S. East Street Stoystown, PA 155q3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Chronic obstructive pulmonary disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that introduced to the cause (Disease or iinjury) Due to (or as a consequence of) Exami ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of starting 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary artery disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24a. Was an 24b. Were autopsy findings available Abdominal_Aortic aneurysm has autopsy prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital

State

29a. Certifier (Check

only one)

31. Date filed (Moeth, Da AUG 0

29b. Signature and title of certified

I. B. Sherman, MD

Olleman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's gnature

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

Registrar

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

August 2, 2011

20850

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1396 Piccard Drive, Rockville, MD

D0052832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month McCall Physician/ 904PM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Rid 90 Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Ohio 1 M M 2 □ F Months Hours Min Oct 4 Day, 1940 70 Director 302-34-2063 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🙀 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21042 9747 Longview Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1958-62 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Social Services Administrator|Non-Profit Organization 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Fitem 27 is marked o မ Graham Alberta Lorena McCallie Albert Rov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9747 Longview Drive Ellicott City, Maryland 21042 Nora Knight McCallie/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ellicott City, MD 8/6/2011 John's Cemeterv 22. Name and Address of Facility Carry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licenses 112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Month Pregnant at time of death the Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ■ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending P after death. Director: After t Certificate: Natural Accident iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🕷 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign ure and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Y 3 Day th 19:50 PM 2011 Venera C. Mirabile 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov . 2 , 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) Hours 1 🗆 M 2 🕱 F Maryland 217-14-2632 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 21228 420 Oak Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc 1 Never Married 2 Married White 1 Yes 2 X No Specify: If Yes, Give Specify: 3 🔀 Widowed 4 🗌 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Santina Angelo Morgano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.Box 176; Pleasant Gardens, NC 27313 Mark Mirabile 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State New Cathedral Cemetery 8/5/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO VASULAR ACCIDEN disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 🗌 Yes 2 💢 No Yes ing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician/ Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Physician/Medical

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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death with the Maryland

then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Menta Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

MIRABIL

VENER

burial-transi cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran certificate funeral director, this : After after death

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Completed

Be

<u>P</u>

Medical Certificate:

25. Was case referred to medical examiner? 1 ☐ Yes 2 ► No	Но	spital:	ER/Outpatient	з 🗆	Other: 4 \(\sum \) Nurs
27. Manner of Death 1 Anatural 5 Pending	on	28a. Date of injury (Month, Day, Year)	28b. Time of injury	M	Injury at work? 1 Yes 2 N

2 Accident investigation		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, date and er: On the basis of examination and/or investigation, in my opinion, death or Practioner: To the best of my knowledge, death occurred at the time, da	occurred at the time, date and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License number 1006580	

To the Hospital within 24 hours a To the Funeral C

State Registrar

HAMMONDS 32. Ragistrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEREYRD BALTIMORE, MO 21227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 201 Tear July 27, 07:01 A M Nathaniel Mozee, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Min (Month, Day, Year) 12-26-1946 Country) 1 **X** M 2 □ F 64 Director 577-62-8564 Usual Residence of Decedent show 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 1215 East West Highway #1116 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced Black Completed Year or Dates 16a Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 yrs Electrical Designer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Thorne Vernon Nathaniel Mozee, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20009 <u>Vanessa Mozee/</u>Sister 16th St. NW #21 Washington, DC other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2011 Washington, DC Glenwood Cemetery Signature of Fureral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home Washington, DC 20011 4217 Ninth Street, NW 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Respiratory Failure Medical resulting in death) **Examiner** Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed <u>Ventricular Tachycar</u>dia the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Congestive Heart Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregne 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No g Unknown 9 Unknown ts been signed by the should be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed' death? 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo ပ 1 🗌 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer work?
1 Yes 2 No injury 1 X Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ap# title of 29d. Date signed (Month, Day, Year) 29c. License number D67589 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 ΜĎ 1500 Forest Glen Road Silver Spring, Maryland Harold V. Lawson 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 24848 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thi 2011 12:56 Hoa Nguyen Ange August Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Min. av 19, Year) Months Hours 586-54-8559 Vietnam 68 May Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗶 No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 United States 20303 Ayoub Lane 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Asian "natural", 3 Widowed 4 Divorced Completed Year or Dates if Health and Mental Hygiene.
Item 27 is marked other than "nature other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate 12 Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) My Thi Do Quat Ding Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, . Page 1 and 2 sl tment of Health *a* **tant: If item 27** is 20303 Ayoub Lane, Hagerstown, Maryland 21742 /Husband David Verzi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 15, cemetery, crematory or other place
Parklawn Memorial Park permit. Page 1
Department of
Important: If it 1 M Burial 2 Cremation 3 Removal from State Rockville, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 20850-2805 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 91715 VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam signed by the attending physician and deed be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown alor Attending Physician: The law requires that the after death.

Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital within 24 hours Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month,

AUG 0 4 2011

MEDICAL GAMPUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11116

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MAGERSTEWN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ 7:32 AM OSTEN MARIE August illiAN 2011 Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARROLI CARROLL LUTTERAN WESTMINSTER If Under If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 1 Year 5. Social Security Number **Funeral** 1 M 2 X F Hours Month, Day, ^{Ye}f 926 Pennsylvania Yrs 84 203-18-8057 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location at the Maryland Director notified 1 ☐ Yes 2 🔀 No Westminster Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral United States 21158 600 Cherrytown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🛭 No If Yes, Give þ 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Home Decor Interior Decorator 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Lillian Marie Miller Edward Joseph Ludwig III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 Cherrytown Rd. Westminster, MD 21158 Norman J. Osten / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Woodbine, Maryland Journey Crematory 8/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Serv Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Examiner use as the burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day the יייפי עווא כפתוזוכמte has been signed by t funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. within 24 hor To the Fune completed fi on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of ath occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, State Registrar

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			1 - State Amend Item	23a per dr.	,8918,08	ertificate of	Death	Reg	. No.				
			1. Decedent's Name (First, Middle, La		10-	C C		Date of Death Month	Day Year	3. Time of Death			
	Physici /Medi		MORTE	NSE	PRES	J		JUNE	11 201	1 10:45 PM			
- mark	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of Deat				
, A			Frederick Villa	Nursing &	Rehab	Catons			Baltimore				
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	of Birth th, Day, Year) 9. Birthplace (Stat Country)				
	Director		220-20-2303		82 Yrs.			Oct 31,	1928 Ma	aryland			
	pur M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
	larylarylarylarylarylarylarylarylarylary	5	MD Balti		Windso					1 □Yes 2 No			
	the //	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventhar must be neithed at once.	Ö	1927 Winder Roa	d		21244	÷		USA				
	leath	Completed by Funeral	11. Marîtal Status	12. Was Decedent Ev	er in U.S. 1	3. Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame				
(0	riter iner	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 X No		If Yes, specify Cuba		Rican, etc.)	Black, White	_{e, etc.} Black			
ဗ္ဗ	urs a	b	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify:	, Lucit			
ည	72 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a. De	cedent's Usual Occup ve kind of work done	ation	sing 16	b. Kind of Business	/Industry			
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П	tal H d oth	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, Ma Mae Bloui					
<u></u> ₹	Men Arke arke	은	Phillip Washing	gton Frazie									
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (ailing Address (Street							
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altimore,	ges 1 It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	sposition (Name of rematory or other place	ce)	Date 20	oc. Eocation - City of	Town, State			
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Bal	bepar Depar mpor my in		21. Signatur of Funeral S. Licer	Wale Dire	ctor	22. Name and Addre			my Board imore, MD	21201			
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-	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					nerth			
		<u>_</u>	Sequentially list conditions,	b. Due to lor as a	Dementi	.a				*			
	rted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Duo to to to a c	ooneogaeneo e.j.								
	execu and al-tra	Xal	that initiated events resulting in death) Last	CDue to (or as a	consequence of):								
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89	ifficat g phy as the	Medical	To a second seco										
ŏ	andin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	2			23d. Date of de	elivery			
œ.	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;y	-	Month	Day Year			
P.O. Bo	it the by th tache	hys	9 🗆 Unknown	9 Unknown									
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D	aquire en si ould b	ed		- H	Zul	Kovil	faila	1 □ Yes	2 □ No 3 □ P	Probably 4 Unknown			
Division of Vital Records,	aw re as be 2 sho	Completed					U	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of			
<u> </u>	The ate h	E O						perform	ed? 🚣 death?	s 2 No			
<u>ta</u>	ian: artific ctor, I	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one,)				
<u> </u>	hysic nis ce I dire		1 Yes 2 No	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Outpa	tient 3 DOA Oth	er: 4 Nursing H	ome 5 Resider	nce 6 ☐ Other (Spe	ecify)			
0	ng P	ü	27, Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time Injur	y Wor	Ŕ?	28d. Describe hov	v injury occurred				
Sio	tendi eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	_			Yes 2 □ No						
≥	or Att	Certification: To	4 Homicide determined		y - At home, farm, <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	iural Houte Number,			
	oital ours a urs a		200 Cartifica d'Acadificia Di	nysician: To the best of	more transcribe alone and	anth annured at the ti	me date and place	and due to the ea	uco(s) and manner	ac etatod			
	Hosp 24 ho Fune etely f	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example (Check only one)	niner: On the basis of a and manner state	examination and/o	r investigation, in my	opinion, death occu	rred at the time, da	te and place, and du	ie to the cause(s)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	29b. Signature and title of cortifier	/ Name state		29c. Licens	se number	29	d. Date signed (Mon	oth, Day, Year)			
	⊢ ≶ F Ö			the the		1	7694	2 7	ul, 20,	2011			
			30. Name and address of person who	completed cause of dea	ith (Item 23a) (Tvi	pe, Print)) 1 1	/					
			B. Tarak			Frede	wick R	d. Cat	a Julle	2011 No 2/228			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar		a. V. J							
	Regist	rar	AUC 0 4 20	11 M. Dune	1. A.	aure							

11-05680 Richard Perry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2011 24851

			1- For State Registrar				С	ertifica	1- For State Certificate of Death Reg. No.										
Phys	icia		1. Decedent's Nam	e (First, Midd	le,Last)								2.	Date of De Month	eath Day	Yea		3. Time of Death	
edical Exa	amir	1er	Richard			Per	rry							July 29,	2011			1657 hrs	
			4a. Facility Name (2045 Griffis		on, give st	reet and n	umber)		41	o. City, T Baltim	own, or Lo	ocation of	Death		4	c. County o	of Death		
Fune	ral		5. Social Security N	Number	6. Sex	_	7. Age (In yrs	s. last birth	nday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of	Birth (MN	I/DD/YYYY		nplace (State or	
Direct			214-66-53	370	1XX	2 F	_	7 Yrs. Months Days Hours Min. Oct 3,1953								- 0	Foreigr Cou	n Intry) Maryland	
		ŀ	Usual Residence o				1 5	57	110.	1				UCE :	19:).3			
A A		ŀ	10a. State	10b. County			10c. C	ity, Town	or Locatio	n								10d. Inside City Limits	
_ A0	ئە	.	MD	N/A			l F	Balti	more									1 X Yes 2 No	
rylan	tonc	륁	10e. Street and Nu							10f. Zip	Code			-	10g. Ci	tizen of Wh	at Coun	try?	
e Mai or 28	notified at once.	uneral Director		Griffi:	_ ^										TTC				
ith th	10ti	<u>_</u>	11. Marital Status	31 11 1 1;		Venue	cedent Ever in	u.s.	21230 S. 13. Was Decedent of Hispanic Origin? (Spec						USA ecify Yes or No- 114 Race - Ameri			can Indian, Black,	
ath v	tat De	e l	1 Never Marri	ed 2 M		Armed F	orces?							ican, etc.)		White	e, etc.		
ter de	E E	ᄪᅵ	3 Widowed	4 X Div	orced If	Yes, Give Ye	2 X No)	1 .	Yes 2	No	specify:				Specify:	Wh	ite	
urs ad	ai ai	d by	15. Decedent's E	ducation (Spe		Dates: highest gra	de completed		Decedent's						16b.	Kind of Bu	siness/Ir	ndustry	
72 ho	al Ex	ete	Elementary/Seco	ontary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)															
O36	Tedic	Completed	10						Ţ	Ware	house							istribution	
5-0 Hygie	the		17. Father's Name	Name (First, Middle, Last)							18 Mother's Name (First, Middle, Maiden Surn						1		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	vent,	Be	John Wa:						dred		-	0.1	7 0 13						
Should M	affic	ဥ	19a. Informant's Na Nickie			_					rai Route N S EOWN		City or Town	n, State,	Zip Code)				
, MD and 2 sho saith and	Tage I		20a. Method of Dis		_					Date			City or	Town, State					
Baltimore, permit. Pages 1 an Department of Hee (mportant: If ite	the	- 1	1 Burial 2		rematory or other place)							lan Burnia Maryland							
ti Pag timent	y or 0		4 Donation 5	Atlan	lantic Crematory Aug. 1,2011 Glen Bu														
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hearth and Mental Hygiera Matural?, or items 23a or 28a-f sho			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Ho																
Physici	an	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											Approximate Interval					
/Medic	cal		failure. List or		1.1.		ive Atheros	sclerotic	Cardio	vascu	ar Dise	ase						Between Onset and Death	
Examin	ier		or condition resulti			•	a consequence												
			Sequentially list co		b														
		ine	if any, leading to in cause. Enter Under	erlying Cause		e to (or as	a consequence	e of):											
18 g	nsit	Examine	(Disease or injury events resulting in		Du	e to (or as	a consequenc	e of):):										
Division of Vital Records, P.O. Box 68760, To the Bopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Diversel. After this certificate has been staned by the attending physician and	the burial - transit	edical	UNPENDED)	¬ <u>" </u>	MENDED													
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787 rtifica	as the	51	23b. Was decedent past 12 months			1 Live	birth	2	Feta	al death	3	Ectopic	pregnand	у		Month	D	ay Year	
Box 687 e death certifi the attending	r use	<u> </u>	1 Yes 2		lam maria	. =	nant at time of	death 5	Oth	er (Spec	ify)								
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duires	ector, page 2 should be det	3	7 (IOO) (IO) / (IO)	7430			-							24a. Wa	as an	24b. V	Vere au	topsy findings available	
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Physical Circuits	al dir	_	1 ✓ Yes 27. Manner of Dea	2 No	1103	اــا'	Inpatient 2		utpatient Fime of In		OA 8c. Injury			Home 5		iury occum		Scene	
Division of Vital Records, P.O. safer detending Physician: The law requires that the safer detending Physician: The law requires that the affector: After this certificate has been staned by	funeral	:uo	1 Natural		ding	(Mont	e of Injury th, Day,Year)	200.	riine or iii			s 2		od. Deserie		ijai y oooaii	00		
SiO Atten	by the	cati	2 Accident		estigation	280 Pla	ce of Injury - A	t home fa	rm street	factory				8f Location	(Street	and Numbe	er or Ru	ral Route Number, City	
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[ospit t hour	ly fill		4 Homicide 4 Homicide 29a. Certifier 29a. Certifier 29c. License number 29d. Date signed (Month, Date 20).										as state	ed.					
thin 2	completely filled in by the	dica											e cause(s)						
å ≅ å	8	¥.	29b. Signature and	d title of certifi		io marmer	stated,			290	License	number			29d	. Date sign	ed (Mor	nth, Day, Year)	
					Q	M	14				O.C.M	I.E.			Ju	ly 30, 20	11		
10			30. Name and add																
1,			Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223																
Re	St gist	ate		oth, Day Year	Dens	32. F	Registrar's Sig	ature											
					4														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ROBINSON 1622 M ENNIS 08 01 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OF BALTIMORE BALTIMORE SINAL HOSPITAL USA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Hours Min (Month, Day, Year! 60 19. 1950 MD 220-54-6417 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. 5104 The Alameda Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Tremont Hotel <u>Shuttle Bus</u> Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robinson Mary Owens 19a. Informant's Name/Relationship (Type, Print)
Paula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mindall Cir., Baltimore, Md 21244 8337 Paul Robinson-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) King Memorial Park 8/8/2011 Woodlawn, 22. Name and Address of Facility
March F/H West
4300 Wabash Av uneral Service Licenses 21215 Ave, Baltimore, Md 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SPIRATION Moussive ase or condition resulting in death) Due to (or as a consequence of): sque tally list condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🕱 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation

that the death certificate be P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: Physician/

Medical

10a. State

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28a-f show

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Maryland 21215-0036

Baltimore,

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permit. Page 1 and 2 should be Department of Health and Men: Important: If item 27 is marke any injury or other traumatic o

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Certificate:

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29a. Certifier

only one)

IF FEMALE:

Examiner

within 24 hours after death.

To the Funeral Director, After this npleted filled in by the To the

ramanik

29b. Signature and title of certifier

6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES 000

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 08 01 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMANIK MBBS SANA HOSPITAL OF BALTHURKE 2401 W BELVEDORE AVE, BALTIMOREMB21219 egistrar's Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 24853 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Kandle **Physician** 0130 4 M 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Perring Parkway Nursing Baltimore Home Parkville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Year) **Funeral** Hours Months Days 1**X** M 2□ F 218-62-2877 /24/1955 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modital Exteninar must be notified at 1 ☐ Yes 2√2 No Director MD Baltimore Parkville 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 USA Funeral 3841 Lyndale Ave Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Unknown Catrelia Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m 3841 Lyndale Ave. Baltimor, MD 21213
e of Disposition (Name of Date 20c. Location - City of Town, State Ruth Randle - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cemet. 20a, Method of Disposition Pages 1 ment of F 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD 18/8/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North 21. Signeture of Funeral Service Licensee Ave. Baltimore, MD 21202 23a, Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma with metastases Physician disease or condition resulting in death) /Medical Examiner decline in Condition 10912551WC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transi Mauguant Due to (or as a consequence of): acture to thrive Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy has 2 00 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28b. Time of 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

P.O. Box 68760 Division of Vital Records,

3altimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Suusman M 821

nth, Day, Year)

32. Registrar's Signature

2011 Menum 31. Date filed (Month, Day, Year) AUG U 4 2011

Monulsman xx

29b. Signature and title of certifier

821. N. Eutuw St. Backemine MD 21201

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 per phy g918 8-31-11 sm
State of Maryland 7 Department of Health and Mental Hygiene 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Ridgley Year Physician/ 22:20 PM NLY 30 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Dec 22 Birthplace (State or Foreign Country) Sex 1 X M 2 □ F Age (In yrs. last bi **Funeral** Months 215-48-7795 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Carroll Sykesville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral USA 21784 6 Bethway Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) landscaping landscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Mae Longmire John Ridgley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 337 Stacy Lee Dr., Westminster, MD 21158 Yvonne Aponte-Rivera (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State Glenwood, MD Glenwood Baptist Cem. 8-5-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Rome & Chapel . Signature of Funeral Service License Parger faight terbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ATHEROSCLERETIC VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or linjury Due to or as a consequence of the attending physician and hed for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown STAGE REMAL within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 2 1 🗆 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ⊅0063303

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,) AUG 0 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULY 30,2011

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires the burial-transit

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certificate funeral director,

within 24 hours after death.

To the Funeral Director: After this

completed filled in by

29b. Signature and title of certifier

Theresa Lorch, M.D.

er

Lus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

page 2 s

and

attending physician

that the death certificate be

ò

Baltimore, Maryland 21215-0036

Joan Rosenberg

State Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) 32. Registrar's Signature 29c. License number

D0052316

1 Texas Station Ct., Suite 210, Timonium, MD 21093

29d. Date signed (Month, Day, Year)

8.2.2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				l Items 2	State of 1	Marylan a-f p e	d/Depa er me Cel	artment 921 <i>dificate</i>	of H	ealth 8 /20 1 eath	and M Lldhb	lental Hy	giene Reg. No.	011	24856		
	Physicia Medic		1. Decedent's Name (Fi	ilson Ro								2. Date of De July	ath 29 Day	20 ⁴ 1	3. Time of Death 1:05 P _M		
-	Examin	ier	4a. Facility Name (if not Citizens Ca	are Cente		7)		4b. City, T Havre	own or le	Grace Grace	of Death CE			ounty of Death	h		
	Funeral Director		5. Social Security Numb 130–12–8421	1 1 🗆	M 2 X F	Age (In yrs. Ia 93	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird 3/27/13					
	ryland I-f show ied at	Director		cedent lb. County Harford			y, Town or Loc	cation				<u>-</u>			10d. Inside City Limits X 1 Yes 2 No		
	ith the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 225 South I	r	reet	1		10f. Zip (Code				100 Citize	en of What Co			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	11. Marital Status 1 □ Never Married 3 ፟፟X Widowed 4 □	2 Married	2. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates		If	13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 І No Specify:							14. Race - American Indian, Black, White, etc. Specify:		
Baltimore, Maryland 21215-0036	within 72 hor giene. er than "nat , the Medica	Completed	(Specify Elementary/Secondar 12	r 5+)	16a. Deced (Give F life. DO Secre	aind of work O NOT use i	done du		t of workii	ng	16b. Kind	of Business I	industry				
land	I be filed Iental Hy rked oth tic event	To Be	17. Father's Name (First, Clifton N.									(First, Middle, Vincen		rname)			
Mary	d 2 should alth and N 27 is ma		19a. Informant's Name/ Wendy R. O			er	19b. Mailin 225 S	g Address (Street ar	nd Numbe St,	er or Rura Abero	Route Numbe	r, City or To D 210	own, State, Zip 01	Code)		
nore,	age 1 and ent of Hes nt: If item y or othe		20a. Method of Disposit 1 Burial 2 X C 4 Donation 5	tion Cremation 3 🗌 Re		20b. P	lace of Disponentery, crem	natory or oth	ner place	anv		Pate 2011		ation - City or Cheste			
Baltii	permit. P Departm Importal any injur		21. Signature of Eunera			11.622											
	Ob sision/	21. Signature of Energl Service Licens. 22. Name and Address of Facility neral Home, P.A. Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
-	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. In um mi A. Due to (or as a consequence of):														
	ed	Examiner	Sequentially list conditi if any, leading to immed cause. Enter Underlying Cause (Disease or injuited)	diate g	Due to (or a	s a consequ	ence of):				0	w /	1	IED.			
_	icate be executed g physician and is the burial-transit	edical Exa	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): CERTIFICATION ATPROVED BY MEDICAL EXAMINER C. Due to (or as a consequence of):														
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iths?	c. If yes, outcom 1 Live Birtl 4 Pregnan 9 Unknow	n 2 🗌 Fetal t at time of d	Ideath 3 🗌	Ectopic pr Other (spe					23	d. Date of deli Month	Day Year		
s, P.O.	r requires that the de been signed by the should be detached	d by P	Part II. Other significan	it conditions cont	ributing to death	but not resu	ulting in the u	nderlying ca	ause give	en in Part	l.		_	_	the cause of death?		
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	he Hosp in 24 ho he Fune ipleted fi	Medical	(Check 2 L	Certifying Physici Medical Examine Certifying Nurse I	r: On the basis of	examination	and/or investi	gation, in m	y opinion	, death oc	curred at	the time, date a	ind place, ar	nd due to the c	ause(s) and manner stated.		
	Voith Con.		29b. Signature and title	of certifier				29c. I	NY	oumber 6 4 1			29d. Date 9	signed (Month	, Day, Year)		
			30. Name and address of	of person who com	rpleted cause of		23a) (Type, P	rint)	Ирь		W	V	210	740			
1	Stat Registra		31. Date filed (Month, Da			trar's Signati		W.									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death more If Under 24 Hrs. If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year, Months Min Yrs. **Director** 28a-f shov 10b. County 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 ✓ Yes 2 ☐ No timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No ρ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced lae the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Nu Jr or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Licensee Funeral Hono, P.A. 222 ac 23a. Part 1/Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final IVER Ph_sician/ Ai disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner feetian Vival DAT Sequentially list conditions, Examiner if any, leading to in medic cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 23a) (Type, Print) and address of person who completed cause of death (Item) N. Chr 670

State

Registrar

31. Date filed (Month, Dav. Year)

AUG 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O 8 Month Physician/ 2011 01 11:12 PM SHIRLEY M. SIPE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 0 9^{Mon#2} (P^{ay,} 1°9°28 82 MD 218 26 5072 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 X No Anne Arundel Pasadena MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ö Funeral items 23a 21122 U.S.A. 8472 Greenway Rd. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No ö 1 Never Married 2 Married ≥ Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Home maker permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Charles M. Kellum Evelyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 8472 Greenway Rd Pasadena, MD Dale Sipe - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Glen Burnie, MD Glen Haven Mem Pk:8/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Home, PA 4D 21122 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Funeral Service Licenses Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ V10-0125 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death the Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by ð Records, 1 Yes 2 No 3 Probably 4 Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director. After this certificate has letted filled in by the funeral director, page 2 s autopsy Yes 2 No 1 ☐ Yes 2 🗷 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 0501 40 Be examiner? Hospital: Other: 1 Tes 2 No ပ DUHR 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the and title of certifier 30 Name and address of person who c of death (Item 23a) (Type, Print) 558 iled (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. artment of Health and Mental Hygiena

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-	Funeral	5		ocial Security Number 6. Sex	M 2 🗆 F	(iii yrs. iast biitiide Yrs	Months	Days	Hours Min.	(Month, Day		Cou		ina
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	show show	jo.		. State 10b. County		10c. City, Town or	Location					- 1	1 Yes 2	
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pu	filed fall Hy ed ott	To Be		Father's Name (First, Middle, Last)	Cannorm	a				Fletcher				
<u></u> ₹	uld be I Men narke natic			rederick Schavoir a. Informant's Name/Relationship (Typ		19b. I	Mailing Addres	s (Street	and Number or Ri			vn, State, Zi	p Code)	
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e,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			a Method of Disposition		20b. Place of I	Disposition (Na crematory or	me of	1	Date	20c. Locat	tion - City or	Town, State	
nor	age 1 ent of ht: If i			1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	74 no 1 To	most C	roma	torsi 8/	4/2011	Woo	dbine,	, Maryla	<u>nd</u>
3altimore,	permit. Page 1 and Department of He Important: If item any injury or othe		21	I. Signature of Funeral Service License		MO1251	22. Name a Going Beverl	nd Addre Home V L.	ess of Facility Cremati Heckrot	on Servi	ice P. Clar	O. Box ksvil	x 784 le, MD 2	1029
	0.012.00		2	3a. Part 1. Enter the dise se, or compl	ications that caused	the death. Do no	t enter the mo	de of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw	veen
В	20.95			shock, or heart failure. List only on mmediate Cause (Final	g cause on caon in								23 mont	hs
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9	ate be ohysic the b	dical			d									
387	ertifica ding p	N.	IF	FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy	3 🗌 Ectopi	o progna	ncv		23	3d. Date of d		Year
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	death.	Certificate:		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e Place of I	njury - At home, fa	ırm, street, fac	tory, offic	ce	28f. Location	n (Street and Town, State)	Number or	Rural Route Num	ber,
Division of Vital Becords.	or Attender after deat Director:			4 1101111010		etc. (Specify)							- stated	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transicompletely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Modical	l cal	29a. Certifier 1 X Certifying Phy (Check 2 Medical Exam	sician: To the best	of my knowledge,	death occurre or investigation	d at the t	time, date and pla pinion, death occur	ce, and due to the red at the time, da	e cause(s) an te and place,	and due to t	he cause(s) and mer as stated	anner stated
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	To the within 2 To the comple			29b. Signature and title of certifier	STO							ust 2,		
				30. Name and address of person who	completed course	of death (Item 23a)	(Type, Print)		D43083					
10				30. Name and address of person who	7 Medical	Center	Dr. Ste	. 30	0 Rockvi	lle, MD	20850			
U.		tate		George Sotos 9707 31. Date filed (Month Day Year) 201	32. Regi	strar's Signature	back	1		2				
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DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SAMUEL Physician/ Month 11:48 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner lhuine enter If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 218-44-8494 1 🗆 M 2 🖵 F Hours Apr. 7 1944 Nountry) 67 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232 N. Dallas St. 21231 USA items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 ₩ Widowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ganson Cunningham ပ Lavra McCullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aisha Samuel (daughter) 521 E. 20th St. Balto, Md. 21218 20c. Location - City or Town, State 20a. Method of Disposition Date 8,20 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Aug,

Compared to the place of the place 1 Burial 2 XCremation 3 Removal from State Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Significant for the rises Calvin B. Scruggs Funeral Home Ε. 1412 Preston St. Balto,Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dvodeual Metastano adeuocarcinoma Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 2 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1—Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type Print Balfinare, 21201 301 81. Paul

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month

04

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar 24861 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 2011 Rosa Grace Treadwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samuritan Hospita N/A Baltimore, Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) N.C. 1 □ M 2 💢 F 7/10/1936 Director 219-32-5078 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 431 Notre Dame Lane 21212 USA)Saら、ireadwel e, Maryland 21215-0036 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify. Specify: Black 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Private Duty Nurse years injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot Suttie Taylor Percy Boone Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Palestine Boone-Sister 1817 N. Dallas St.Balto., MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Purial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Loudon Park Cemt. 8/3/2011 Baltimore, MD Donation 5 Other (Specify) March F/H 1101 E. North 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or se a consequence of, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Colostomy Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performe death? 2 N 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 24862 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cert	tificate of	Death				Reg. No.			
Physicia		1. Decedent's Name (First, Middl	e,Last)					2.	Date of D	leath Day	Year	3	Time of Death
~ત્યાંcal Exami	ner	Anthony Tarb	ert						August	1, 2011	1 Cal		0430 hrs
		4a. Facility Name (if not institutio	n, give street and n	umber)	41	c. City, Town, o	r Location o	of Death		4c. 0	County of	Death	
	•	1123 Cooks Lane Rea 5 Social Security Number	= 1123	. Hodoore	La La	Baltimore							
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Ye	ar If Unde	r 24Hrs.	8. Date of	Birth (MM/DI			place (State or
Director		215-45-1216	4 Tth 0 T	15		Months Day	ys Hours	Min.	A	16,199		Foreign Coun	try) MD
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ź	H	Usual Residence of Decedent 10a State 10b County		10c City	Town or Location	ın .						I	Od. Inside City Limits
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aryland 8a-f sho at once,	5	MD		Вал	timore								
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of Wha	at Countr	у?
72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be notified at once		1110 Cooks Lan	e			212	229			U	SA		
with the rs 23a se noti	ē	11. Marital Status		cedent Ever in U.S		Decedent of H				No- 1-			n Indian, Black,
death or iten	uneral	1 X Never Married 2 Married	arried Armed F	orces?	If Ye	s, specify Cuba	ın, Mexican,	, Puerto Ri	ican, etc.)		White,		
iter d	ഥ	3 Widowed 4 Div	orced If Yes, Give Ye		1	Yes 2 X N	o specify:			s	pecify:	Whit	e
2 hours after "natural", Examiner	à	15. Decedent's Education (Spe-	or Dates: cify only highest gra	de completed)	16a. Decedent					16b. Kir	nd of Bus	iness/Ind	lustry
5-0036 led within 72 hou Hygiene other than "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working lif	e. DO NOT	use retired	d)				
	힐	9			S	tudent					Stud	ent	
215-003(be filed within ntal Hygiene rked other tha ent, the Medic	ő	17. Father's Name (First, Middle,	Last)				18.Mother	's Name (F	irst, Middl	le, Maiden S	urname)		
file Hy	a						M		Maria	Seri	_		
2121: uld be fill Mental F marked c event,	O O	Richard Joseph 19a. Informant's Name/Relations			19b. Mailing	Address (Stre						. State. Z	Zip Code)
MD 2 d 2 shou Ith and N n 27 is n	E	l .	, ,		1	•							,
ore, ML ss I and 2 s of Health at If item 27 her traums		Nancy Tarbert 20a. Method of Disposition	Mother	20h P	lace of Disposit	ooks La			Date			City or To	own, State
ages I and 2 shount of Health and N: It: If item 27 is in other traumatic		1 Burial 2 X Cremation	Removal f	[rematory or oth		orriotory,					,	,
MOF Pages nent of ant: If	1	4 Donation 5 Other S	pecify:	Bal	to-Wash	Cremat	cory	8/6/	2011	Lau	rel,	MD	
Baltimore, permit. Pages I ar Department of Her Important: If ite	X	21 Signature of Funeral Service		1	22. Na	me and Addres	ss of Facility	Ste	rling	Asht	on S	chwa	b Witzke
E E E		VXOINO VOL	- Kulla	uch	Fur	eral Ho	ome of	Cat	onsvi	lile,	Inc.	о M	n 21228
Physician		23a. Part I. Enter the disease, or	complications that	caused the peath.	Do not enter th	e mode of dying	, such as c	ardiac or r	espiratory	arrest, shoc	k, or hea	rt ,	D 21228 Approximate interval Between Onset and
Medical	UЭ.	failure. List only one cause	O	Vounds (2) of	Torse and I	oft Thiah							Death
≟xaminer		Immediate Cause (Final disease or condition resulting in death)		a consequence of		-cit i nign							
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8760, tificate be ex ng physician as the burial	₩.	IF FEMALE:	23c. If yes	outcome or pregn	aricy						Date of		
68 ertifi ding		23b. Was decedent pregnant in the past 12 months?	LIVE		=	al death 3	Ectopi	c pregnanc	СУ	N	/lonth	Da	y Year
Box 687 e death certific the attending the to use as the	Sici	1 Yes 2 No 9 Unl		nant at time of dea	oth 5 Oth	er (Specify)							
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ViS r At rer d rirect n by	ij		28e. Pla	ce of Injury - At ho	me, farm, stree	t, factory, office	building, et						Route Number, City
DIVI	Certification:			Local Stree	et			111	100 blk o	n, State) f Wedgewo	ood Roa	d, Baltii	nore, MD
Hospital 34 hours z Funeral tely filled		00. 0.16	hysician: To the be	est of my knowledg	e, death occurr	ed at the time,	date and pla	ace, and d	ue to the c	ause(s) and	manner	as stated	
hin the	Medical		miner:On the basis	of examination ar									
To wit	Mec	29b. Signature and title of certific	and manner er	stated.		29c. Licer	nse number			29d. D	ate signe	ed (Mont	h, Day, Year)
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		Musia		D					_				
Y A		30. Name and address of person				D - IV	04		MDG	1000			
		Melissa Brassell, MD		edical Examin		. Baltimore	Street, B	altimore	e, MD 2	1223			
		31. Date filed (Month, Day, Year)	32. F	legistrar's Signatu									
Regis	trar	AUG 0 4 2011	Wagnes !	A. par	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 08^{Month} 02 2011 7:45 AM BILL FRANK VAUGHN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Drive Severna Park Arunde1 Anne Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min 20 3914 83 Kentucky Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 335 North Drive 21146 U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 \(\square\) No 1950 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced 1951 White Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Tavern Owner Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bryan Vaughn Goldie Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 North Dr. Bryan Vaughn - Son Severna Park. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran' 8/5/11 S Crownsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses GJ Gonce Funeral Home, PA 169 Riviera Pasadena, Dr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Caro disease or condition resulting in death) USE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ves, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

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Certificate:

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Baltimore, Maryland 21215-0036

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o the Funeral Director: Aft

P.O. Box 68760

Division of Vital Records,

	illre	1X Yes 2 No 3 Probably 4 Unknown
Chrone of	studine boywash gizon	24a. Was an autopsy performed 1 Yes 2 No No No No No No Yes 2 No No No No No No No
25. Was case referred to medical	26. Place of Deat	th (Check only one)
examiner? 1 Pes 2 No	Hospital: 1	ursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and r iner: On the basis of examination and/or investigation, in my opinion, death oc se Practioner: To the best of my knowledge, death occurred at the time, date	ccurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year)

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State Registrar

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ed cause of death (Item 23a) (Type, Pri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g919 9-1-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ VERNON **AVERY** WHITE 2011 0210 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD CO UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Social Security Number 1381 8. Date of Birth (Month, Day, Sept 29 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Hours Min MARYLAND T961 **Director** Yrs 49 013-54-1572 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director injury or other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2XX No MARYLAND HARFORD CO ABINGDON 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral items 23a U.S.A. 21009 502 NANTICOKE CT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 Alo ò 1 XNever Married 2 ... Married Ş Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONWAYS DEPT STORE COC 12th grade RETAIL and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ MILDRED L BOND LUCIEN R. WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 502 Nanticoke Ct., Abingdon, Md., 21009 <u> Veronica Matthews/Sister</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 KMBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) James Cemetery 08/05/11 Havre de Grace, Md. 21. Signature of Far ral every second WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical Box 68760 the as IF FEMALE for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day signed by the al d be detached fo P.O. 23e. Did tobacco use contribute to the cause of death? ģ lomo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to prédical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🛂 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 2011 Mame and address of persen who completed cause of death (Item 23a) (Type, Print) 500 Date filed (Month, Day, 32. Registrar State 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Maryland	/ Depa	rtment of H	lealth and	Mental Hyg	giene	1 1	21005
			State Registrar		Cer	tificate of E	eath		Reg. No. U	11:	24865
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Wade	•			2. Date of Dea	o3 2	Year	3. Time of Death 2:30 AM
me.	Medic Examin		4a. Facility Name (if not institution, give str			4b. City, Town, or	Location of Deatl		4c. County	of Death	2 90
	k		Bethesda Nursing a	nd Rehab Cente	er	Bethes	sda		Monte	gomery	7
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	Year)	9. Birthpla Countr	ace (State or Foreign
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	and show Lat	or	10a. State 10b. County	10c. City,	Town or Loc	ation			· · · · · · · ·	10	d. Inside City Limits
	Maryl 28a-f stified	Director	Maryland Montgome:	ry		Silve	Spring				1 ☐ Yes 2X No
	h the a or a	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	th wit ms 23 must	Funeral	703 Tanley Road		140.11	20904		16 - Ma Na	Unite		
·O	or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱No	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puert	o Rican, etc.)		e - America ck, White, et	
9	rs afte ral", Exan	ed b	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates.	1	Yes 2 X No	Specify:		Specify	Bla	ck
2-0	within 72 hours after death with the Maryland gjenn than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occupa ind of work done d	ation Juring most of war	kina I	16b. Kind of B	usiness Indi	ustry
2	thin 7.	No	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	NOT use retired)		9	Educat	ion	
2	ed wi' Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)	5+	Teach	er	18. Mother's Nar	me (First, Middle, i	Educat Maiden Surnam		
<u>la</u>	ld be filed Mental Hy iarked oth atic event	욘	Llewellyn C. Tho	nas			Lila I		_	,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mertal Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street a			City or Town,	State, Zip Co	ode)
	and 2 s Health em 27 ther tr		Ruth Dian Mericle			Tanley Ro	d. Silve	r Sprinq			
Baltimore,	0 4		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Re	emoval from State cen	netery, crem	sition (Name of natory or other place		Date	20c. Location		
₫	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Licensee	Flinal		ney Crema					aryland
Ba	permi Depar Impor any ir once.		Augusta la Latte	hate MO12	G5 251 Be	ing Home verly L.	Cremation Heckrot	on Servi te, P.A.	ce P.O. Clarks	Box ville	784 MD 21029
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one								Approximate Interval Between
·	hysician/	0.3	Immediate Cause (Final disease or condition	Debili	+4					1	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequer		2	nen h	101			
		ier	Sequentially list conditions, b. if any, leading to immediate	td v cl V	1 CC	(C	MEVI II	4			
	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	CAT)						
	ate be executed hysician and the burial-transit	EX	that initiated events c. resulting in death) Last	Due to (or as a consequer	nce of):				,		
90	ate be ohysici the bu	edical	d.			_					
687	sertific Iding I	/We	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnanc					23d Ds	ite of delive	v
Box	eath o	icia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnanc Other (specify)	у				Day Year
0	t the d by the	Physician/Me	9 Unknown	9 ∐ Unknown							
o.	Attending Physician: The law requires that the death certificat ar death. **Ta death.** **Ta d	by	Part II. Other significant conditions cont	ributing to death but not result	ing in the ui	nderlying cause giv	en in Part I.				e cause of death?
ğ	requir been should	Completed						24a. Was a			sy findings available
Division of Vital Records,	sician: The law r certificate has b irector, page 2 sl	duc						autop perfo	sy med2	prior to con death?	pletion of cause of
<u>e</u>	an: Th tificat tor, pa		25. Was case referred to medical			26. Pla	ace of Death (Che	1 \(\sum \) Yes ck only one)	2 KJ No	1 🗌 Yes	2 L No
<u> </u>	ysician: is certific director,	To B	examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 🗆 DOA Othe	r: 4 Nursing H	lome 5 🗆 Resid	ence 6 🗆 Oth	er (Specify)	
T O	ing Pl		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	ed	
SIO	ttend death stor: A the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	e form etro		Yes 2 No	28f. Location (S	troot and Numb	or or Pural I	Pauta Number
>	al or A safter Direct d in by		4 Homicide determined	building, etc. (Specify)	c, iaim, and	et, lactory, office		City or Tow		ei Oi nuiai i	toate Namber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical		an: To the best of my knowled r: On the basis of examination a							
	the H thin 24 the F mplet	Me	unly unes 3 Dentifying Nurse I	Practioner: To the best of my k	navor investi navor investi navor investi navor investi navor investi navor investi navor investi navor investi navor investi navor a superior investi navor a superi	veti unnumed at the	time, date and pla	ion and during the	cous (s) and m	enner as ste	list.
	6 ₩ 6		29b. Signature and title of certifier	alleret	1 (R	29c. License	472	26	29d. Date signe	a (Montin, D	ay, rear)
		- 3	30. Name and address of person who com	npleted cause of death (Item 2)	3a) (Type, Pi	rint)	, , ,		0	11	MDZOS
			10110 ME	lecular		Am.	e 2	206	Kolle	V11/4	MUZOS
	Stat Registra		31. Date filed (Month, Day, Yéar) NIG 0 4 2011	2. Registrar's Signatur	far	les !					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 24866 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day} 2ď11 12:35 AM August Ralph Curt Wittig Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9545 Persimmon Tree Road Potomac Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 71 Months Hours April II, Year 940 216-38-3687 Connecticut Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 🛣 No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a United States 20854 9545 Persimmon Tree Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 Yes 2 No Black, White, etc. item 27 is marked other than "natural", or other traumatic event, the Medical Examin 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Audio Production Recording Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even once. မ Ralph Louis Wittig Anne Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Sanoey Circle, SE, Vienna, Virginia 22180 Kathyrn W. Gressang /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State August Bethesda, Maryland Montgomery Crematorium, Inc: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. maris 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 10 next and Death Immediate Cause (Final Cardiovascular Disease Ph_sician/ disease or condition resulting in death) Atherosclerotic Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 No Yes page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 X No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 X Yes 2 🗌 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending -1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature 29d. Date signed (Month, Day, Year, August 2, 2011 D33554 who mpleted cause of death (Item 23a) (Type, Print) 5410 Connecticut Avenue, NW #117, Washington, D.C. 20010 Yerg II, MD John/E. State AUG 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month UST Physician/ 5:00 AM Marv В. Zepp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year, Director 217-38-4145 18 Ĩ921 MD Nov Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Carrol1 Westminster 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 201 St. Mark Wav Apt. 208 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Black White etc. ō 1 Never Married 2 Married by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin auton. If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) education school teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 D. Beirne Pue Annis Crockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Bell (daughter) 7844 E. Hill Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) View Cemetery 8-5-11 Marriottsville, MD ^{22. Name and Address of Facility} Haight Funeral Home & Chapel P.A. P.O. Box 195 Sykesville,Md. 21784. 21. Signature of Funeral Service Licensee Parax 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition , Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29d. Date signed (Month, Day, Year) 3 20/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emerson Walden M.D. 300 St. Luke Circle Westminster, Md. 21158. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 1

			For State Registrar	State of Marylan		artment of Heartificate of Dea			iene 2 ()	24868	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	st)			-	2, Date of Deat Month		Year	3. Time of Death	
	Medic		Thomas	С.		Albaugh		July 9,			9:22 A.M	
	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or Loc				nty of Death		
	Euporol		Kline Hospice Hous 5. Social Security Number 6. S	ex 7. Age (In vrs. In	ast birthdav)	Mt. Air	Under 24 Hrs.	8. Date of Birth		derick 9. Birthpl	ace (State or Foreign	
	Funeral Director		213-24-8494 Usual Residence of Decedent	X M 2 □ F 81	Yrs.	Months Days Ho	ours Min.	(Month, Day, Nov. 25.	Year) 1929	Countr Mary	Land	
	yland -f show ed at	ctor	10a. State 10b. County Maryland Frederi		y, Town or Lo					10	ld. Inside City Limits 1 ☐ Yes 2 🛣 No	
	e Mar r 28a notifi	Director	10e. Street and Number	CK	rrede	10f. Zip Code		- 1	IOa Citizan	of What Count		
	/ith th		5548 Etzler Road	*		21702			rog. Citizeri c	USA	, , ,	
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.1	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spe	ecify Yes or No-		ace - America		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		f Yes, specify Cuban, M 1 □ Yes 2 🗽 No S		Rican, etc.)		lack, White, et		
21215-0036	72 hour n "natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Indu									
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br	filed valued val	Be	17. Father's Name (First, Middle, Last)			18.	. Mother's Nam	e (First, Middle, N	∕laiden Surna	me)		
ylaı	ld be Menta arked atic e	욘	Guy M.	Albaugh			Graçe	I	Humm			
Baltimore, Maryland	2 shoul Ith and 27 is m traum:		19a. Informant's Name/Relationship (7 April Lynn Steve			ng Address (Street and I			•		ode) s, PA 17252	
<u>6</u>	permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	-			n - City or Tov		
m	Page nent o int: If		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Tierrievai ironi otate		natory or other place) et Cemetery	7/13	/2011	Frede	rick, l	MD	
alti	permit. Pag Departmer Important any injury once.	1	21. Signature of Funeral Service Licens			2. Name and Address of						
Ö	o a L C	- 9	1 Lone W M	war	1 1	.621 Opossu	mtown P	ike, Fre	ederic	k, MD	21702	
	Ph. sician/ Medical Examiner	66 TS	23a. Part \Enter the disease, or com shock, or heart failure. List only c Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat ne cause on each line. Pneumothorax Due to (or as a consequ	:	er the mode of dying, su	uch as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death	
00	e be executed ysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)								
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 0	al death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ry Day Year	
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of Vital	hysician: The la his certificate ha I director, page 2	To B	examiner? 1 ☐ Yes 2 ☐ X No	Hospital:	ER/Outpatie	nt 3 DOA Other:	1 ☐ Nursing Ho	ome 5 🗆 Reside	ence 6 X C	ther (Specify)	Hospice	
on of	nding Ph ath. r: After th e funeral		27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident Investigatio		28b. Time o injury	28c. Injury at work?		28d. Describe ho			•	
Division	spital or Attendii ours after death. eral Director: Af filled in by the fu	I Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (St City or Town		nber or Rural	Route Number,	
_	To the Hospital within 24 hours a To the Funeral Completed filled	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	n and/or inves	tigation, in my opinion, d	leath occurred a	t the time, date ar	nd place, and	due to the cau	se(s) and manner stated.	
	Voith Com		29b. Signature and title of certifier	2 hu	~	29c. License nur D00551		2	29d. Date sig July	ned (Month, E 14, 2	2011	
	\mathcal{O}_{l}		30. Name and address of person who Dr. John C. Luca.			od Blvd.,	Freder	ick, MD	21703			
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	ha. d. 1						

11-05534 Charlie Mack Allen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 24869

		1- For State Certificate of Registrar	Death	Reg.	No	
Physicia	ın/	Decedent's Name (First, Middle, Last)		Date of Death Month D	ay Year	3. Time of Death
ledical Exami	ner	Chair it chack Arren	Oit Town on Location of Double	July 25, 201	1 4c. County of De	0529 hrs
)		4a. Facility Name (if not institution, give street and number) 7320 Finns Lane	b. City, Town, or Location of Death Lanham		Prince Geo	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or
Director		579-24-1151 1XM 2DF 84 Yrs.	Months Days Hours Min.	Nov.5	1026 Fo	reign North CountCarolina
	ł	Usual Residence of Decedent		INUV.J.	1920	
r any		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once.	5	Maryland Prince George's Lanham				
Mary r 28a- ed at	Director	10e. Street and Number	10f. Zip Code		Citizen of What C	ountry?
MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once		7320 Finns Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	20706 Decedent of Hispanic Origin? (Sp		SA 14 Bace - An	nerican Indian, Black,
ath wi	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc	
fter de		1 Yes 2 No No No No No No No No No No	Yes 2 No specify:		Specify: W	hite
2 hours a "natura"	d b	45 Decedent's Education (Capaign only highest grade completed) 169 Decedent	s Usual Occupation (Give kind of w st of working life. DO NOT use retir	/bo	b. Kind of Busine	ss/Industry
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			Metropol	itan epartment
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	E	6 Police	Officer 18.Mother's Name			epar dilette
of filed al Hyg	BeC		Mary Ell		,	
212 ald be Ment mark		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or R		r, City or Town, S	tate, Zip Code)
MD d 2 sho lith and m 27 is		Stacy Berg/ Daughter 8288	Elvaton Road Mil	lersvill	e, MD 21	108
Fe land Fleat	Ш	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other contents of the content of the cont	tion (Name of cemetery, er place)	Date 2	Oc. Location - City	or Town, State
Pages nent o		Baltimore Cremate	er place) e Washington orv 7/2	8/2011	Laurel, I	MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med	ı	21. Signature of Funeral Service Licensee 22. Na	ame and Address of Facility Rob	ert E. E	vans Fund	eral Home
	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	000 Annapolis Ro	ad Bowie	shock, or heart	Approximate Interval
Physician		failure. List only one cause on each line. Atherosclerotic C	ardiovascular Di	sease co	mplicate	d Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	спетшта			
		Sequentially list conditions, b.				
	iner	if any, leading to immediate — Due to (or as a consequence of). cause. Enter Underlying Cause				- 8
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and trans		d. 220 pt II 27 28	a-f par ma g010	0-8-11 cr	<u> </u>	
760, icate be executed physician and the burial - transit	Medical	X AMENDED 23a, pt. II, 27, 28 23a per me g919	9-13-11 vt			
8760, ificate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetting Fetting 1	al death 3 Ectopic pregna	ncy	23d. Date of deli Month	very Day Year
Box 687 e death certific the attending of	icia	past 12 months? 4 Pregnant at time of death 5 Oth	er (Specify)			
ш ° ≅ в Г	Physician	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	adortuing cause given in Part I	23e Did toba	cco use contribute	e to the cause of death?
ires that the signed by I be detach						Probably 4 Unknown
ords, w requires is been signatured by	ted	Remote head trauma with parapregia a	nu bilaterar	24a. Was an		autopsy findings available
COF law re has b	Completed by	amputation		autopsy	ed? death	
ital Recorician: The law is certificate has becorded as			26.Place of Death (Check	1 Yes 2	No1 ✓	Yes 2 No
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n of Viding Physical After this funeral dir	£	27. Manner of Death 28a. Date of Injury 28b. Time of In	jury 28c. Injury at Work?	28d. Describe hov	v injury occurred	
lendin eath.	ğ	Natural 5 Pending Investigation Fd 7-25-11 fd 5:05	am 1 Yes 2 No	subject o		to hot
Division of Vital Records, P.O. tal or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree		28f. Location (Stre or Town, Stat	et and Number or	Rural Route Number, City
Spital nours refilled	Cer	4 Homicide determined (Specify) Residence		Lanham, M	ld.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 2 Medical Examiner: On the basis of examination and/or investigati	ed at the time, date and place, and on, in my opinion, death occurred a	due to the cause(s t the time, date an	s) and manner as : d place, and due t	stated. o the cause(s)
To T	Medica	and manner stated. 29b. Signature and tible of certifier	29c. License number	2	9d. Date signed	(Month, Day, Year)
		The Soll of the	O.C.M.E.		July 27, 2011	
		30. Name and address of person who completed cause of death (Item 23a)				
O Le			. Baltimore Street, Baltimo	re, MD 21223		
S Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHMH 17 Rev 1/2		JUL 2 9 2011 Server B. Jack				
PUNIT IT KeV 1/2	JUI	OCUE	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death :58am Physician/ WILLIAM RUFUS ADAMS, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Plate La charle Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 4 - 2 7 4 9 4 1 WASH.,D.C. h2hb£ 69 215-38-5889 Yrs Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director LA PLATA CHARLES 1 ☐ Yes 2X No MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20646 6825 HAWTHORNE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc à 1 ☐ Yes 2 ☐Xlo If Yes, Give 1 Never Married 2 XMarried 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.GOVT. CARPENTER 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EUNICE VIOLA PICKERAL WILLIAM RUFUS ADAMS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 3455 PORT TOBACCO RD. NANJEMOY, MD. 20662 WILLIAM J.ADAMS SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 8-3-11 ALEX., VA. 21. Signature of Juneral Service Licensee 2. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cycles in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Unknown 1 Yes 2 9 Unknown the cate has been signed by to page 2 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Probably 4 🗌 Unknown 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform After this certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or/investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death urred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1084 Name and address of pe on who completed caus

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 0 4

32. Registrar's Signature

prooke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | | 2487 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	icate of	Death			Reg. No.		
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd EVELINE		2. Date of I Month June 20	Death Day	Year	3. Time of Death 1156 hrs				
		4a. Facility Name (if not institution 933 Park Avenue	on, give street and nu	mber)	4	b. City, Town, o Laurel	r Location o	of Death		c. County of Prince Ge	
Funeral Director		5. Social Security Number 339-26-9114	6. Sex	7. Age (In yrs. last b	birthday) Yrs.	If Under 1 Ye Months Day		Min. NOV	Birth(MM/ 27 332		9. Birthplace (State or Foreign JLLINOIS Country)
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Locatio	on				-	10d. Inside City Limits
k	ğ	MD PRINC	E GEORGE	S	LA	AUREL 1XXYes 2 10f. Zip Code 10g. Citizen of What Country?					
h the Mary 3a nr 28a	I Director	10e. Street and Number 933 PARK AVENUE 10f. Zip Code 20707									STATES
TOTE, MD 21215-0036 spes 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23s arr 28s-f shoother traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 Di	1 Yes vorced if Yes, Give Yee or Dates:	d Forces? If Yes, specify Cuban, Mexican, Puerto Ricán, etc.) White Yeer 1 Yes 2 X No specify: Specify:							HITE
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 1 2 T H			during mo	s Usual Occupa st of working life TINTE CASH	RVIE			ARLOS	ness/industry FURNITURE ORE
5-00 led wit tygien other	5	17. Father's Name (First, Middle	, Last)			CASII		s Name (First, Midd	le, Maiden	Surname)	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	JAMES 19a. Informant's Name/Relation:	BARNHI		40L 34-III	A -l-1 (0)	MRY	YTLE FE	RRIS	3	0.4.7.0.4.
ore, MD 2 ss 1 and 2 shoul of Health and M of Health and M of Health and M of Francatic		RITA BARNHIL						ber or Rural Route REET, WAU			
Baltimore, M permit. Pages 1 and 2 Department of Health Impartant: If item 2 injury nr other traun		20a. Method of Disposition 1 Burial 2XX Crematio 4 Donation 5 Other S	pecify:	om State RIVE	RDALI EMATO	DRY		JULY 19 2011	, RI	VERD	ity or Town, State ALE , MD
	- 1	21. S nature of Funeral Service TERRENCE L. JOHNSON #M00993 4433 WHITE PLATIS LANE, WHITE PLAINS 23. Name and Address of Facility JOHNSON FUNERAL SERVICE TERRENCE L. JOHNSON #M00993 4433 WHITE PLAINS LANE, WHITE PLAINS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximately									
Physician IN dical Examiner											Between Onset and Death
<u> </u>	-	Sequentially list conditions, if any, leading to immediate	b	consequence of).							
d Sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):							
execut an and al - tra	edical	UNPENDED	d AMENDED								
ox 68 eath certication attending for use as	201	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 Ur	he 1 Live b	ant at time of death	2 Feta	al death 3 er (Specify)	Ectopic	pregnancy	23	d. Date of de Month	elivery Day Year
P.O. Es that the gned by the e detached	<u>\$</u>	Part II. Other significant condi	tions contributing to	death but not result	iting in the ur	nderlying cause	given in Pa				ute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d ars after death. *I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	Completed		-	10					/as an utopsy erformed?	pri	ere eutopsy findings available or to completion of cause of ath?
Vital Rec ysician: The I his certificate I director, page	S							1 Y Y	es 2 N		Yes 2 No
ician:	8	25. Was case referred to medical examiner?	I to an italy	npatient 2 ER	//Outpatient			(Check only one) Nursing Home 5	Reside	ence 6	Other: Scene
of Viring Physics After this Physics After the Physics After th	٤	1 ✓ Yes 2 No 27. Manner of Death	28a Date	of Injury 28	b. Time of In		ury at Work	? 28d. Descri	be how inj	ury occurred	
ion ttendii feath.	atio		stigation Jun 20,	2011 11	OUND: 147 hrs		Yes 2	No			
Divisation A straight of A str	Suicide Could not be determined (Specify) home or Town, State) 933 Park Avenue, Laurel, MD								or Rural Route Number, City		
Division of Vits with the Hospital or Attending Physicis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directorial or the funeral direction of the funeral direction	Medical C	(Orlow orly	Physician: To the bes aminer:On the basis of and manner s	of examination and/o							
H 3 F 8	¥	29b. Signature and title of certification				29c. Licen		00445			(Month, Day, Year)
		30. Name and address of person	who completed caus	JA, se Fdeath (Item 23a	nu.)	0.0	.M.E.	OCME	Jun	e 21, 201	11
182		Theodore M. King, Jr	., MD. Assista	int Medical Exa	miner 9		more Stre	eet, Baltimore,	MD 212	23	
Sta Regist		31. Date filed (Month, Day Year	2011	egistrar's Signature	par	the !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18^{bay} EVELYN ELIZABETH BROWN JULY 2011 5:09 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 💢 F 220-18-7664 98 **Director** PEŇŇŠÝLVANIA Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MARYLAND HARFORD 1 X Yes 2 □ No ABERDEEN 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a 1529 MEADOWCREST COURT 21001 UNITED STATES Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give ٥, Completed by 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced BLACK "natural" Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVICE VA HOSPITAL is marked other Be and 2 should be filed Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES ANDERSON MAMIE MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traceone. MONROE C. BROWN/ SON 1529 MEADOWCREST COURT, ABERDEEN, MARYLAND 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BERKLEY CEMETERY 07/23/11 4 Donation 5 Other (Specify) DARLINGTON, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, 552 LEWIS STREET, HAVRE DE GRACE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **PNEUMONIA** Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjur g physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE attending nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ led by the atter detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 XNo 1 Yes 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available after death.

Director: After this certificate has I autopsy prior to completion of cause of death? page To the Hospital or Attending Physician: The 1 Yes Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ပ္ 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 **X** Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural work? 5 Pending 2 \square No Accident Investigation within 24 hours after dex To the Funeral Director completed filled in by th 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check X Gertifying Nurse Fractioner: To the best of my knowledge death onto dust the time, date and plane, and due to th 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIÉ JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

2011

JULY

EVELYN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Type of Marking & Separation of Health and Mental Hydienes And Legible.

	•	For State Registrar		State or Ma	aryiand		tificate of E			Reg. No	2011	24873
Physicia		1. Decedent's Name	e <i>(First, Middl</i> e, <i>La</i> : Diane	st) Brewei	c				2. Date of De Month July	ath Da	¥ 201	3. Time of Death 8:49 P _M
Medic Texamin			-	e street and number) Memorial Ho	nani+	2]	4b. City, Town, or	Location of Deatl	1		County of Deat Freder	th
Funeral		5. Social Security N	umber 6. S	ex 7. Age	e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Bir	thplace (State or Foreign
Director		219-46-6 Usual Residence of	Decedent	1 M 2 M F 64	-00				107027	1946		untry) OH
laryland ka-f shc ified at	Director	10a. State	10b. County Freder:	ick		Town or Local						10d. Inside City Limits 1 ☐ Yes 2 No
th the N 3a or 28 t be not	al Dir	10e. Street and Nun					10f. Zip Code 21754		Ţ	10g. C	itizen of What Co	ountry?
death wi	Funeral	11. Marital Status		12. Was Decedent E	ver in U.S.	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	USA	14. Race - Ame	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Harried 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	- 1	☐ Yes 2 A No		o rican, etc.)		Black, White Specify:	_{e, etc.} White
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2 should th and N 27 is ma trauma		19a. Informant's Na					g Address (Street a					•
of Heali of Heali if item 2		20a. Method of Disp	oosition	Jr./husban Removal from State	20b. Pla	ace of Dispos	Perismmo sition (Name of atory or other place		Date Date		ocation - City or	
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permi Depar Impo any ir once,	113) (1/	49.	1/W		10	621 Oposs	umtown I	Pike, Fr	eder		•
Physician/		shock, or hear Immediate Cause (t fal List only o Final	plications that caused one cause on each line	0	Do not enter		, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Medical examiner		disease or condition resulting in death)		a. Due to (or as a		nce of		5210	rome			5-7 Lays
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ficate be executed g physician and ss the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	injury s	c. Due to (or as a	conseque	nce of):						
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the dear	Physician/N	1 Yes 2 9 Unknown		4 ∐ Pregnant at 9 ☐ Unknown	time of de	ath 5 🗆	Other (specify)				Month	Day Year
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has beer ge 2 shoul	Completed by								24a. Was	psy	prior to	topsy findings available completion of cause of
ician: The la certificate ha rector, page	Be Con	25. Was case referre	ed to me di cal	-			26. Pla	ce of Death (Che	1 🗆 Yes	2 N	death? 1 ☐ Yes	s 2 🗆 No
ding Physician: After this certific funeral director,	유	examiner? 1 Yes 2 2 27. Manner of Death		Hospital: 1 Inpatie		R/Outpatient	3 DOA Othe	r: 4 Nursing F	lome 5 Resid			cify)
ending sath. or: After he funer	Certificate:	1 Natural 2 Accident	5 Pending Investigation	(Month, Day		injury	28c. Injury work' M 1 🗆	at ? Yes 2 🗌 No	28d. Describe h	now injur	y occurred	
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2	☐ Medical Exam		amination a	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	and place	e, and due to the	cause(s) and manner stated.
within 2 To the comple	Σ	only one) 3 29b. Signature and	title of certifier	se Practioner: To the	best of my r	anowleage, a	29c. License		ice, and due to th		te signed (Monti	
		30. Name and addre	ess of person who	mpleted cause of de	eath (Item 2	23a) (Type, Pr	rint) _	65378	<u>, </u>	Ju C	15,	2011
10 State		LEV 31. Date filed (Month	1	FREUNO	r's Signatu	M	. D. 4	00 M	7th St	- F	recleric	KMD 2170
State Registra		•	JUL 18 2	177 Gran	A J	1. 10	all					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day 2011 Year 7:00P M 11 Peggy Marie Brooks Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Northampton Manor Care & Rehabilitaion **Examiner** Frederick Frederick 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 6. Sex March 25, 1927 Min. MaryTand Hours **Funeral** 215-20-8975 1 □ M 2 🖾 F 84 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State items 23a or 28a-f sho her must be notified at Director 1 🗌 Yes 2 🍱 No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21704 Funeral 6038 Bartonsville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc **Black** 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Specify: 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Axia Turner ၉ Charles White, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 5935 Bartonsville Rd., Frederick, MD 21704 19a. Informant's Name/Relationship (Type, Print) Leona Montano / Daughter 20b. Place of Disposition (Name of certal extra a very company of other place)
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation Frederick, Maryland 4 Donation 5 Other (Specify) Skkot Cody P.A Resthated Fuffer al Services, 21. Signature of Fune Service Licen Frederick, MD 21701 9501 Catoctin Mountain Hwy. Þ cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease, or com 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Interval Between ne cause payeach line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): **Medical** Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or linjury as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery use 23b. Was decedent pregnant Year Month Day in the past 12 months?

1 Yes 2 No ρ 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy has performed Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 2 1 Tes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at Manner of Death Certificate: injury work Director: After Natural 5 Pending 2 🗷 Yes Accident Investigation 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours Medical 29a. Certifier completed (Check within 2 To the only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

B

ack

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Grace Virginia Bowlus 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Frederick **Examiner** 2703 Old National Pike Middletown 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2. / 30 / 40 Country) MD Months Days Hours 70 219-36-2880 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location
Middletown 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director MD Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral USA 21769 2703 Old National Pike 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Black. White, etc. ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify.White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) postal service mail carrier Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last)
Walter S. Bidle Jr. 18. Mother's Name (First, Middle, Maiden Surname) ပ Grace E. Flook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 McClellan Ave., Boonsboro, MD 21713 19a. Informant's Name/Relationship (Type, Print) Sherri Taylor (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lutheran cemetery 7/11/11 Middletown. Donation 5 Other (Specify) Sonature of Fu Licensee BonardddrBsof FTWompson Funeral Home Middletown, MD 21769 POB 18. 3a. Part 1. Enter the disease, or co ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) *≟*xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident☐ Suicide neral Director; A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10 State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL

M'Corneck

32. Registrar's Signature

29c. License number

41667

(conjus)

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Registrar Amend#15Perfuneralhome7/25/19ectificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jul 1 7:07P M McRather Cooney Janet 201 Medical 4a. Facility Name (if not institution, give street and number) nty of Death 4b. City, Town, or Location of Death **Examiner** HAR MEDICAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 26, 1939 119-34-2496 Months Days Hours Min. 71 Director Massachusetts Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 🛛 No Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5404 Well Spring Road 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Completed 3 → Widowed 4 □ Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the Homemaker 4 Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Janet Gray Wilard Franklin Rand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Cooney/Son P.O. Box 484, La Plata, MD Department of Healt Important; If item 2 any injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 7/21/2011 uneral Service Signature of M01458 22 AREHARTSECHÜLS FUNERAL HOME, P.A. 20646 Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1/21 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed 2 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie se number 29d. Date signed (Month, Day, Yea who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Reg

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 24877

		1- For State Registrar		Certi	ficate of i	Death			Reg. No.		
Physici		Decedent's Name (First, Midd	e,Last)					2. Date of D	eath		3. Time of Death
Medical Exam		Joshu	a Todd Ch	andler				July 28,	Day 2011	Year	1703 hrs
		4a. Facility Name (if not institution			41	c. City, Town, or Lo	ocation of [. County of I	Death
		University of Maryland	1.00			Baltimore					
E		5. Social Security Number	6. Sex	7. Age (In yrs. last	hirthday)	If Under 1 Year	If Under 2	AHrs Is Date of	Birth (MANA)	ויייייסת	9. Birthplace (State or
Funeral Director					. Dirtriday)	Months Days	Hours	Min.	•	F	ForeignMary1and Country)
Director		214-17-2692	1∑M 2☐F	30	Yrs.			June	19,	1981	Country)
		Usual Residence of Decedent									
any		10a. State 10b. County		10c. City, To	own or Location	n					10d. Inside City Limits
nd Jhow	-	Maryland C	ecil		Po	rt Depos	it				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	당	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citi:	zen of What	Country?
or 2	Director	1016 Winch Ro	ad				21904			U.S	5.A.
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	_	11. Marital Status		edent Ever in U.S.	13 \Mas	Decedest of Hisp	ania Origini	? (Specify Yes or I	No.	14 Page - 4	American Indian, Black,
ith w	Funeral	1 Never Married 2 M	etc.								
-	교	11	White								
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hour:	þ	15. Decedent's Education (Spe				S Usual Occupations of working life. I					ness/Industry ree Service
6 1 72 Eal	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Laborer					ast, Maryland
15-0036 filed within 72 I Hygiene. Ad other than "	Ē	Twelve Years	ast, maryrand								
Fed ya		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be	C1ift	on Chandl	er, Jr.		İ		Sandr	a B1	evins	
ould d Me	ို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									
MD 12 sho th and 1.27 is		Clifton Chandle	er, Jr. (father)	1016	Winch Ro	ad, P	ort Depos	51t,	Maryl	and 21904
e, land Healthealthealthealthealthealthealthealth		20a. Method of Disposition				on (Name of ceme	etery,	Date	20c.	Location - C	ity or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 X Burial 2 Cremation		om State St.	matory or othe Mark 's	Cemeter	v	08/03/11	Pe	rrvvi]	lle, Maryland
tran representation		St. Mark's Cemetery 08/03/11 Perryville Donation 5 Other Specify. St. Mark's Cemetery 08/03/11 Perryville Lee A. Patterson & Son Funeral Home									
Sal Separ		M.	Licensee	/_	Le Le	e A. Pat	terso	n & Son	Fune	ral Ho	ome, P.A.
		23a. Part I. Enter the disease, or	HEERICK	-,30		Perr	yvi11	e, Maryl	and	21903	3-0766 Approximate Interval
Physician Medical		failure. List only one cause		aused the death. D	o not enter the	mode or dying, si	uch as card	liac or respiratory a	arrest, snc	ock, or near	Between Onset and
Examiner		Immediate Cause (Final disease	a. Anoxi	c Brain	Injury						Death
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death)		consequence of):							
		Sequentially list conditions,		ble Mult	i-Drug	Intoxica	ition				3
	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):							1
	٦	(Disease or injury that initiated	C. Due to (or as a	consequence of):							
red Insit	Exa	events resulting in death) Last	d	consequence or,							
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760, icate be ex physiciar the burial	edical					. Pol	6,10				
3760, ficate be g physics the bur	ΣI	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregnar			Tetenia a		230	d. Date of de	elivery Day Year
68 certif	ä	past 12 months?	I Live L	oirth nant at time of death] Ectobic bi	egnancy		Month	Day Teal
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be h. After this certificate has been signed by the attending physici funeral director, page 2 should be detached for use as the buri	Physiciar	1 Yes 2 No 9 Uni	known 9 Unkn		5 Othe	r (Specify)					
D. B t the d by the	된	Part II. Other significant condit			ulting in the un	derlying cause giv	en in Part I	23e. Dio	I tobacco	use contribu	ite to the cause of death?
i, P.O.	à		g			,			es 2	No 3	Probably 4 V Unknown
S uires								_ //			
y red	Completed							24a. Wa	opsy	pric	ere autopsy findings available or to completion of cause of
eco ne law te has ge 2 sl	Ē		-					per	formed?	dea	ath? ✓ Yes 2 No
tal Rection: The certificate		25. Was case referred to medica				26 Place o	f Death (Ch	neck only one)	, 2	· •	100 2 10
ician s cer	a	examiner?	Hannital:	Inpatient 2 Ef	R/Outpatient		*	lursing Home 5	Pacida	nce 6	Other:
f Vi Physi er this	입	1 Yes 2 No			Bb. Time of Inju						
n of \ding Ph. After the funeral	崩	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred									i
ttenc death ttor:	cation	Pending Investigation fd 7-22-11 fd 3:00pm 1 Tes 2 No unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route									
Division of Vital Records, ral or Attending Physician: The law requir rs after death. **I Director: After this certificate has been siled in by the funeral director, page 2 should I	ij		d not be	e of Injury - At home	e, farm, street,	factory, office bui	lding, etc.	28f. Location or Town	ı (S treet a . State)	nd Number 1016 V	or Rural Route Number, City Linch Rd. d.
ours pita	Certifi	4 Homicide	mined (Specify)	home				Port I)epós	it, M	d.
Hos 24 h Fun	cal	(Ontour only	nysician: To the bes								
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ,	edic	one) 2 Medical Exa	miner: On the basis and manner s		or investigatio	n, in my opinion, o	death occur	red at the time, da	te and pla	ice, and due	to the cause(s)
F 3 F 3	N N	29b. Signature and title of certifie		- /		29c. License	number		29d.	Date signed	(Month, Day, Year)
			In .	1/		O.C.M	.E.		July	30, 201	t
		30. Name and address of person	Who completed care	se of death (Item 23	Ra)	1					-
		·	uty Chief Medi		•	altimore Stree	t, Baltim	ore, MD 2122	3		
	ata		•								
5	tate trar	31. Date filed (Month, Day Year)	<i>h</i> .	egistrar's Signature	es that						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Department	artment of Health and M rtificate of Death		ene g. Ro. 0	24878	
	9		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death	
	Physici /Medic		Vernon Dale Carey		7 1	2011	10:20 A M	
	Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat		
			509 Tritapoe Drive	Knoxville If Under 1 Year If Under 24 Hrs.	O Date of Birth	Frederick 8 Birthology (State or Foreign		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 63 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1 3/29/1	Year) Co	thplace (State or Foreign buntry)	
h			Usual Residence of Decedent	310 1111	7-000			
	rylan how	L	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits	
	Ba-f s	cto	MD Frederick Knoxy	ille			1 ☐ Yes 2 No	
	vith th	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?	
	s 23s	ral	509 Tritapoe Drive	21758	noith Vac or No	USA 14. Race - Ame	arican Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Rican, etc.)	Black, Whit	e, etc.	
21215-0036	hour tural		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation	10	6b. Kind of Business	ite	
7	in 72 n "na fedic	plet	(Specify only highest grade completed) (Give	kind of work done during most of works DO NOT use retired)	ing	op. Kind of business	moustry	
212	d with giene r tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Watter	Plant Operator		Brunswick Ci	ty Cov.	
5	e file al Hys r othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name				
<u>yla</u>	Ment Ment arked atic e	To I	Vernon Carroll Carey	Katherine	e Drucill	la Lancast	er	
Maryland	2 short and is m			ng Address (Street and Number or Rura			Zip Code)	
	1 and Health em 27 ther t		Sharon Carey, Wife 509 20a. Method of Disposition 20b. Place of Dispo	Tritapoe Drive, Kr		MD 21/58 0c. Location - City or	Town State	
Baltimore,	nt of l		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)				
뜶	artme ortant injury			ts Cemetery 7/18/. 2. Name and Address of Facility	2011 B	runswick MD		
Ba	Depa Impo any ir			John T Williams Funeral	L Home, Bru	ınswick MD 2	1716	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	· -	or respiratory arres	st,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death) a	n Heart Failure			Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	2 :				
	Lamine	<u>.</u>	Sequentially list conditions,	ANTENY 1) 13 8430			7 y cars	
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury					
	af-tra	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit		d					
9	tificate ig phys as the	Physician/Medical						
Box	th cer endin	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 []Ectopic pregnancy		23d. Date of de		
	e deal	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year	
<u>Р</u> О	d by the	Phy	9 LL Onknown	4.4.4	22a Did tabe	acco use contribute to	e the equippe of death?	
ds,	The law requires that the death certific the has been signed by the attending p nage 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			robably 4 Unknown	
Vital Records,	requ	Completed	0	· D ·				
Rec	has has ge 2 s	mp	Peripheral vasular occli	MILE VISCASI	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
æ	ician: Th certificate rector, pag	e Co	25. Was case referred to medical		1 ☐ Yes 2	☑No 1 ☐ Yes	s 2□ No	
	ysicia is cert directo	o Be	examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatie	Other	n (Check only one		acifu)	
0	g Phy er this eral c	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		outy)	
0	nding Fath. r: After e funera	atlo	1 ☑ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No				
Division of	I or Attendated after deatl Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
	ital o rs aft ral Di led in							
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)	
	To the Ho within 24 I To the Fu completel	Med	29b. Signature and Mile-of certifier	29c. License number	29	d. Date signed (Mont	th, Day, Year)	
)	ه≒۶		Manland MD	1) 2203		7/14/		
				Print)		, , , , , ,		
	10		LEONARD KINLAND 610 97	Print) Th ANE BRUN. bake	SWICK	MD.	217/6	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1-41				
	Registr	ar	JUL 18 2011 Senera D. A.	Barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State o	f Marylar		artmen <i>tificate</i>			and M		giene Reg. No.	011	24879
Physicia Medic		1. Decedent's Nam Mary E. (Last)							2. Date of De Month	ath July 16, 2	011 Year	3. Time of Death 03:35 AM M
Examin		4a. Facility Name (ii Egle Nurs i		give street and num	ber)		4b. City,		ocation of			4c. Co	unty of Deat egany	h
Funeral Director		5. Social Security N 220-26-75	i49	6. Sex 1 □ M 2 ⊠ F	7. Age (In <i>yr</i> s. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir Month Da Septembe	th Y 09 ,"1926	9. Birl	thplace (State or Foreign aryland
ıryland a-f show ied at	ctor	Usual Residence of 10a. State Maryland	10b. County	gany		ty, Town or Loc	ation		•				··· <u>-</u>	10d. Inside City Limits 1 🛣 Yes 2 □ No
vith the Ma 23a or 28¢ st be notif	Funeral Director	10e. Street and Nur		4 Vale Summ			10f. Zip	Code 532-				10g. Citizen	of What Co	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Mari 3 🖫 Widowed		Armed For	2 No	If		ify Cuban	, Mexican,		cify Yes or No- Rican, etc.)		Black, White	rican Indian, e, etc. hite
within 72 hou giene. er than "natı er the Medica	Completed	(Spe Elementary/Sec 12	ecify only highe	t's Education et grade completed) College (1-	4 or 5+)	life. DO		rk done du retired)	tion <i>uri</i> ng most	of workir	ng	16b. Kind o	of Business	Industry
d be filed Mental Hy arked oth	To Be	17. Father's Name ((First, Middle, La inebrenne							r's Name ys Th o	(First, Middle, O mas	Maiden Surr	name)	
id 2 shoul salth and I n 27 is ma		19a. Informant's Na Gladys R		19b. Mailin					Route Numbe		vn, State, Zij aryland	21532-		
Page 1 ar nent of He ant: If iten ury or oth			position Cremation 5 Cher (S	Place of Dispos cemetery, crem Frostburg	natory or o	ther place)		Date 20c. Location - City or Town, State Frostburg Maryland					
permit. Departr Imports any inju		21. Signature of Fundal Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, N											urg, MD	21532
Physician/		shock, or hea Immediate Cause	rt failure. List o (Final	complications that comply one cause on each	ch line.							rest,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	ì	Due to (LZITE or as a conseq	uence of):	<u> </u>	(1)	-M1	-1V /	1)4			*
uted d ansit	edical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying iinjury	Due to (or as a conseq	uence of):								
sate be executed physician and the burial-transit	ical Ex	resulting in death)		Due to (or as a conseq	uence of):								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med												livery Day Year	
ss that the igned by t be detach	by	94 77 3 4		ns contributing to de	eath but not res	sulting in the u	nderlying o	cause give	en in Part I.					the cause of death?
aw require as been s 2 should	Completed										24a. Was	an 2	4b. Were au	tropsy findings available completion of cause of
ian: The la rtificate ha tor, page :	Be Con	25. Was case referr	red to medical					26. Plac	ce of Death	h (Check	1 Yes	ormed?	death?	s 2 No
Physical r this ce eral direc	으	examiner? 1 Yes 2	h h	28a. Date		28b. Time of		Other 8c. Injury	4 W Nur		me 5 Resi			ify)
28d. Describe how injury occurred work? 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work?								umber or Ru	ral Route Number,					
Hospital c 4 hours at uneral Di ed filled ir	Medical C			Physician: To the be	est of my know	ledge, death o					d due to the ca	use(s) and m		ated. cause(s) and manner stated.
To the h within 24 To the F	Me		Certifying	Nurse Practioner:			leath occur		time, date				d manner as	stated.
8		00 No	7	trish	o of al11 "	- 02+) (T:		026	90	7		Tul	1 18,	2011
nows		Harjit	Sidhu		shop Wa	lsh Roa		umbei	cland	, MD	21502			
Stat Registra		31. Date filed (Mont	th, Day, Year)		egistrar's Signa	ture bar	Ked							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Month Dawn Combs July. 9:56 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 614 Shriver Avenue Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 218-16-4355 86 **Director** 04/19/192 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 614 Shriver Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 😾 No Specify. Completed 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file marked Ε. ပ Stahlman Howard Clyde Violet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Shriver Avenue. Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Douglas Combs / Son 614 Shriver Avenue, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vet Cem @ Rocky Gap 07/18/2011 Flintstone, MD Signature of Funeral Service Lices 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 En the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on , ach line, Immediate Cause (Final Physician/ elestatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or as a our sequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death signed by the a d be detached t g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page, 2 🔲 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 140 ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) **Natural** 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director,

Baltimore, Maryland 21215-0036

Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To-the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 14, 2011 D35135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas E. Chappell, M.D., 912 Seton Drive, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 11:00 AM Barbara Ann Culp Medical or Location of Death Eacility Name (if not institution, give street and number, 4c. County of Death Examiner 5 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) If Under 1 Year 8. Date of Birth 6. Sex **Funeral** 1 □ M 2 F (Month, Day, Year) 08/20/1943 213-42-0357 67 Yrs **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 X No MD Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S. 21851 2807 Sheephouse RD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. P þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker 11 Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anne Mae Smith Norman Moses Outten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Sheephouse RD Pocomoke City MD 21851 Bobby Culp/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 07/22/2011 Pocomoke City MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility f Holloway Funeral Home P.A.Pocomoke City MD 21851 107 Vine St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1DN/12 Y CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner BRTRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Yes □ No. 1 Yes 2/1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Ves completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at $5 \square$ Pending Natural work 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

2

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Registrar's Signature

WAR

31. Date filed (Month, Day, Year)

21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner ounty of Death **Funeral** 1 M 2 W **Director** 215-91-1499 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other trailmatic months. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 100 ni Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ecedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Completed by 1 Never Married 2 ☐ Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced \mathcal{B}' Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) Baltimore Crematory 7/14/2011 Baltimore, MD Signature of Funeral Service Decrease John M. Taylor Funeral Home, Duke of Gloucester St. Annapolis. MD 21401 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ∳hysician/ disease or condition resulting in death) day Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2 No 1 Plnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Matural 5 Pending degth. 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation within 24 hours after dect To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 201 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) ann 31. Date filed (Month, Day, Year) State 1 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 16, Day 2011 Ralph Duffy 7:07 p^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12701 Veirs Mill Road Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Dec. 9, 1927 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country 1 🏝 M 2 🗆 F Months Days Hours Min. 83 **Director** 198-14-1665 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ian "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 Yes 2 No MT Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12701 Veirs Mill Road 20853 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give WWII era 1 Yes 2 No Specify. Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the Roman Catholic Priest Religious other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ralph Duffy, M.D. Anna Gregoria Gislon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Ann M. Lee/Sister 379 Lyons Road, Basking Ridge, NJ 07920 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place) Metropolitan Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francis Address Collyins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Opter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Gunshot Wound of Head Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): -transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 No signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed' Yes 2 X No 1 🗌 Yes 25. Was case referred to medical examiner? 2 No Other: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death Certificate; 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1
Natural 5 Pending work? 1 ☐ Yes 2 No solf-inflicted 30m + bal 16 2011 Accident Investigation 6 Could not be 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City pr Town, State) 27 O/ VIETS MILL Home the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: Toythe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certific ٩ 20+1 D00426 mo DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 Wawkes 5vr N BRECKER mo oms

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUL 21 2011

Silver S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death JULY 20. 2011 LYNELL WALTER DADE 10:05A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES FORT WASHINGTON MEDICAL CENTER FORT WASHINGTON Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours SEPTEMBER 21, 1964 MARYLAND 213-82-8530 46 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 9935 BUNKER HILL ROAD 20603 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Black, White, etc 1 ☐ Yes If Yes, Give 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PEARL LILLIAN FOX FENWICK JOHN WALTER DADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9935 BUNKER HILL ROAD, WALDORF, MARYLAND 20603 CORLETTE DADE / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ST. PETER'S CHURCH CEM. 4 ☐ Donation 5 ☐ Other (Specify) JULY 30,2011 WALDORF, MARYLAND Ture of Funeral Service Doen e THORNTON FUNERAL HOME, LIDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD. INDIAN HEAD, MARYLAND 20640 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 人 disease or condition resulting in death) Due to (or as a consequence of)

Ph_sician/ Medical Examiner

the attending physician and hed for use as the burial-tran

been signed by the attendin should be detached for use

After this certificate has

s after dea. -al Director: After

To the Hospital within 24 hours a To the Funeral I

Be

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Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Department of H Important: If ite any injury or oth once.

Physician/

Medical

Director

Funeral

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Completed

Be

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10a. State

Examiner

Funeral

Director

. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. That if Item 27 is marked other than "natural", or items 23a or 28a-f sho that if Item 27 is marked other than "natural", or items 23a or 28a-f sho iun or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Due to (or as a c

Year

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown Completed by

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown

h	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

1 💋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3e. Did tobacco us	se contribute to the cause of death?
1 ☐ Yes 2 	No 3 ☐ Probably 4 ☐ Unknown
4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

23d. Date of delivery

25.	Was case referred to medical examiner? 1 Yes 2 No
27.	Mariner of Death

Natural

29a. Certifier

Accident

Hospital: Anpatient 28a. Date of injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of injury

28c. Injury at 1 Yes 2 No

26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 ☐ Suicide	6 ∐ C
4 Homicide	de
	^

Investigation ould not be termined

5 Pending

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

(Check only one)				and place, and due to the cause(s) and manner stated the cause(s) and manner as stated.
b. Signature	and title of contifier	m	29c. License number	29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>)

Other:

WASHINGTON MEDICAL CENTER 11711 LIVINGSTON ROAD, FORT WASHINGTON, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT AMIR MIRZA-ALIKHANI. M.D.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Mary State Registrar	land / Der	ertificate of E	lealth and I Death		2011	24885	
Physicia Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Magdalena Pastore Diehl				2. Date of Dea		3. Time of Death 10:35 PM	
Examir		4a. Facility Name (if not institution, give street and number) Glade Valley Nursing & Rehabi	litatio		Location of Death		4c. County of Dea		
Funeral Director		5. Social Security Number 552-32-6443 6. Sex 1 ☐ M 2 🖾 F 7. Age (In)	9. Bir	thplace (State or Foreign nuntry) (Unk •)					
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c Maryland Frederick	City, Town or L	ocation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
with the M 23a or 28 ist be noti		10e. Street and Number 2502 Catoctin Court	Tred	10f. Zip Code	1702		10g. Citizen of What Co	ountry?	
Iryland 21215-0036 Ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ted by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	n U.S. 13	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 2	i (Giv	edent's Usual Occupa e kind of work done d DO NOT use retired) Homemak	luring most of worl	king	16b. Kind of Business Own Ho		
land 2	Be	17. Father's Name (First, Middle, Last) Dominic Fostore			18. Mother's Nam				
, Maryland of 2 should be file saith and Mental In 27 is marked of er traumatic eve		19a. Informant's Name/Relationship (Type, Print) Scott Diehl / Son		•			City or Town, State, Zi		
Baltimore, Marylan permit. Page 1 and 2 should be fine Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce.		1 Rurial 2 X Cremation 3 Removal from State	cemetery, cr	position (Name of ematory or other place n Cremator	y July	Date 9, 2011	20c. Location - City or		
Ball permit Depart Impor any in		21. Signature of Man Service Lensee		22. Name and Addres Resthaven 9501 Catoc	Funeral tin Moun	Services tain Hwy	, Skkot Co . Frederic	dy P.A. k, MD 21701	
Priysician		23a Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause Final disease or con filon #epatocell A Hepatocell A Hepat			g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death 2 yrs.	
Medical Examiner	_	resulting in death) Due to (or as a con Sequentially list conditions.	sequence of):						
ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury that initiated events							
/60 cate be executed physician and s the burial-transit	ledical E	resulting in death) Last Due to (or as a condition of the condition of th	isequence oi).						
OX 68 ath certifications attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Cother (specify)	у		23d. Date of de Month	slivery Day Year	
that	by	Part II. Other significant conditions contributing to death but no	t resulting in the	underlying cause giv	en in Part I.		bacco use contribute to	o the cause of death?	
KeC The law ate has page 2	Completed					24a. Was a autop: perfor 1 Yes	sy prior to med? death?	ntopsy findings available completion of cause of	
VITAL HC nysician: The nis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2	2 ER/Outpati	Othe	ace of Death (Checer: 4 🔯 Nursing H		ence 6 🗆 Other (Spec	cify)	
On Of anding Pl sath. or: After the ne funera	Certificate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Yea	28b. Time injury	work'		28d. Describe ho	ow injury occurred		
LIVISION OT tal or Attending Phrs after death. al Director: After the death by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Springle 1)	At home, farm, s ecify)	treet, factory, office		28f. Location (Si City or Town	Street and Number or Rural Route Number, wn, State)		
DIVISION Of VITAL To the Hospital or Attending Physician: within 24 hours after dearth. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king physician: To the best of my	nation and/or in	estigation, in my opinio	n, death occurred a	at the time, date ar	d place, and due to the	cause(s) and manner stated.	
vith To		29b. Signature and title of certifier auf num	~	29c. License D 139		2	7/9/2011	h, Day, Year)	
5		30. Name and address of person who completed cause of death (Robert L. Kaufmann M.D. 30		Print)	Frederic	k, MD 21	701		
Sta Registr	te ar	Robert L. Kaufmann M.D. 300 31. Date filed (Month, Pay, Year) 5 2011 32. Redistrar's Si	ignature	pare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 24886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEVORE Month LEE 1200 1 777 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional medical Allegany 8. Date of Birth
(Month, Day, Year)
4-15-1936 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 🗷 M 2 🗆 F Director or items 23a or 28a-f show miner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ALLEGANY ELLERSLIE 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral SHAFFER STREE1 10119 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 🗆 Widowed 4 🗆 Divorced Specify: WHITE Year or Dates other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. SERVICE Auto MECHANIC Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ROBERT DEVORE MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21529 DEVORE/WIFE 10119 SHAFFER ST POBOX 193 DELORES ELLERSLIE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) HUNDMAN, PA 7-18-11 4 ☐ Donation 5 ☐ Other (Specify) PALO ALTO CEMETERY 21. Signature of Funeral Service Lice 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL HOME INC 169 CLIARENCE ST HONDMAN PA 15545 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Panh disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): he law requires that the death certificate be executed burial-transit After this certificate has leen signed by the attending physician and funeral director, rage 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown q | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 2. No the Hospital or Attending Physician: Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 2| 1 🗌 Yes 2 No 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 24 hours after death. Funeral Director; A 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, c. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certil ing Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical examiner: On the basis of examination and/or investigation, in my online, date and place, and due to the cause(s) and manner stated the order of the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated the order of the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated the order of the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated the order of the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated the order of the cause(s) and manner stated the order of the cause(s) and manner stated the order of the cause(s) and manner stated the order of the cause(s) and order order of the cause(s) and order (Check within 2 29b. Signature and title of certifie 29c. License number 18,2011 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) 924 SETON DR. Cumberland DR. VIKRAMADITYA POONAT MO 21502

State Registrar 31. Date filed (Mo

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | | 24887 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 1^{Day} CATHERINE **EVANS** 2011 11:18 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL ELKTON CECIL Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2**X** F 09/20/1925 **Director** 202 20 6515 85 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If ifter 27 is marked od ther than "natural", or items 23a or 28a-f sho amportant; If item 27 is marked of other than "natural", or items 5.8 or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD CECIL EARLEVILLE 1 X Yes 2 □ No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28 KENT ROAD 21919 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: WHITE 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FINISHER PAPER COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT HAYES CAROLINE WHEELAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN A. SMITH 301 DELTA ROAD, WILMINGTON DE 19810 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State LAWN CROFT CREMATORY 7/25/11 LINWOOD, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DE 19805 MEALEY FUNERAL HOMES, PO BOX 2866, WILMINGTON M00784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Due to (or as a construence of): disease or condition resulting in death) Edlilla Medical **Examiner** Cardiomyerath Securitially let conditions if any, leading to immediate cause. Enter Underlying Examine -transit Hitch Disease or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Cononaci Due to (or as a consequence of): burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2. No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Since Mikal regulation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chrisic Renal 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No Division of Vital completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined the Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66176 Lawa 2011 14(1) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SHARMA. Elkton MA 21921 106 BOW Smeet 31. Date filed (Month, Day, Year) = ● * ● 32. Registrar's Signature State Registrar

PVANS.

ATHER INE

	-	For State Registrar		,	Certificate of		,	Reg. No.				
Physicia	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day									3. Time of D	Death M	
Medic Examin		4a. Facility Name (if not institution, give	4b. City, Town,	b. City, Town, or Location of Death 4c. County of					101			
		Western MD Regio		1 Cente		erland	8. Date of Bir		11egan	y place (State or	Fa va inv	
Funeral Director		007-32-7248	□ M 2 □ F		rs. Months Days		(Month, Da 04/25/	y, Year) 1935	Cour		roreign	
yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Allega		10c. City, Town	or Location tstone					10d. Inside City Limits		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmportant if frem 27 is marked other than "naturalr," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number		1 1 1 1 1	10f. Zip Code			10g. Citizer	n of What Cou	1 🗌 Yes 2	2 A 1 No	
	Funeral	10103 Town Creek			2153				U.S.A.			
irs after dea ural", or ite I Examiner	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12, Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		Race - Ameri Black, White, ecify: Wh			
ithin 72 hou ene. r than "natu the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+		Decedent's Usual Occu (Give kind of work done ife. DO NOT use retired	during most of wor)	king		of Business Ir	ndustry		
d be filed w Mental Hygi arked other itic event, i	ø	17. Father's Name (First, Middle, Last) Edward Gilbert J		1	Nurse Prac	18. Mother's Nar	me <i>(First, Middle,</i> h Gertru	Maiden Sun	name)			
nd 2 should ealth and N m 27 is ma er trauma		19a. Informant's Name/Relationship (T) Earl F. Eaton, J			Mailing Address (Stree 0103 Town (1530	
Page 1 al ment of H tant: If iter jury or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	5)	cemetery	Disposition (Name of crematory or other plane C. Rocky Ga	ap 07/1	Date .5/2011		tion - City or T .ntston			
permit Depart Impor any in		21. Signature of Funeral Service Licens	Lincher)	22. Name and Addr	ene St.,	church Cumber1	Funera and,	lb ^н 2Т5	602 ^{P.A.}		
hysician/		23a. Part 1. Enter the or lease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Severe Pulmonary Hypertension Approximate Interval Betwee Onset and Deat Years										
Medical Examiner		resulting in death)				years						
- +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sclerade Due to (or as a of	consequence of):					y car b		
	cal Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a d	as a consequence of):								
	Medical	IF FEMALE:	d									
the attending	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 T No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date Month 1 ☐ Live Birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ Month 1 ☐ Windown 1 ☐ W								rery Day Ye	ar	
signed	ا ۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ★No										
certificate has been rector, page 2 should	Completed	. Type 2 Diabetes Mellitus 24a. Was an autopsy performed 2- 1 Yes 2 No								Were autopsy findings available prior to completion of cause of death?		
ertifical		25. Was case referred to medical examiner?	17			Place of Death (Che		2 A No	1 Yes	2 L NO		
this light	욘	27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day,	28b. Tir	ury woi	4 □ Nursing H ry at	lome 5 Residence 1			y)		
s after deal	Certificate:	2 Accident 3 Suicide 6 Could not b 4 Homicide determined	a 		n, street, factory, office	100 2 2 110	28f. Location (S City or Tow		umber or Rura	l Route Number	r,	
in 24 hours aft the Funeral Dir pleted filled in	Medical	(Check 2 Medical Exami	sician: To the best of miner: On the basis of exa se Practioner: To the be	amination and/or	investigation, in my opin	ion, death occurred	at the time, date a	ind place, and	d due to the ca	use(s) and mann	ner stated.	
S with		29b. Signatur and title of certifier	South 1	m)	29c, Licens	18216			gned (Month, 1y 11,			
3		30. Name and address of person who of Stephen R. Smith	completed cause of dea	ath (Item 23a) (Ty 2501 Wi	pe, Print) 11owbrook 1	Road, Cum	berland,	MD	21502			
Stat Registra	-	31. Date filed (Month, Day, Year)	32. Registrar's		han bed							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2e0 1 Certificate of Death

1 - For State Registrar

T.	6 7		1. Decedent's Name	(First, Middle, Las	st)						2. Date of Dea			3. Time of Death
201	Physici		MARGAR	ET	ELIZABETH EDELEN						JULY	28	2011	11:05A ^M
	/Medic Examin		45 Ch T						or Location					
96.5	LAdillii		GENESI	S WALDO	RF CENTE	WALDO	WALDORF					CHARLES		
	Funeral		5. Social Security N	umber 6. S	ex 7. Ag	e (In yrs. last	birthday)	If Under 1 Year			8. Date of Birtl (Month, Day	h (Year)	9. Birthp	lace (State or Foreign
3.	Director		212-38-	4156	□м 2 ў ў F	88	Yrs.	Months Days	Hours	Min.	DEC.1		22 MAR	YLAND
	p _		Usual Residence of											
	rylar	L	10a. State	10b. County	0	10c. City, To							1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma	cto	MD	CHARLE	S 	WA.	LDOF	(F						
	ith th	Director											zen of What Cour	
	23e	ral	12571	SUBSTA	TION ROA	D		206					J. S. A	
	r deg	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of I If Yes, specify Cub	Hispanic Or pan, Mexica	rigin? (Spe in, Puerto f	crfy Yes or No- Rican, etc.)	1	 Race - Americ Black, White, 	
36	or if	by Fu	_	ed 2 Married	1 ☐ Yes 2 🔀! If Yes, Give	Vo.		1 ☐ Yes 2 √ √0	Specify	:			Specify:	mra
8	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-1 show or other treumatic event, the Medical Examination number notified at	q p	X Widowed		Year or Dates:		- D	41-1010				10h K:	WHI	
21215-0036	"nel	lete	(Spec	15. Decedent's Edify only highest gra	ide completed)	''	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of workir	ng	IOD. NI	nd of Business/In	dustry
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Maryland	d be antal) Be	ALOTS	SHLAGE	т.						OBELIE			
2	should be nd Mental marked o	<u>م</u>	19a. Informant's Na			1	9b Maili	ng Address (Stree	1					Code)
<u>8</u>	d 2 sho th and t7 is m treum		DORIS P		DAUGHTE	1								
Ġ,	ges 1 and 2 t of Health if item 27 or other tr		20a. Method of Disp		DAUGHTE	20b. Place	of Dispo	NESTLA Disition (Name of		AUGU			cation - City or To	
altimore,	Pages nent of It ont: If Its				Removal from State	1		matory`or other pla CR ^I S CEM				F.7.7	TDODE	MD
틀	it. P intme inten- injury		21. Signature of Fu	5 Other (Specif		191.1			-	1, 2			LDORF,	
Ba	permit. Pag Department Importent: I any injury o		L'A	1 BoA	-(()	M00641		2. Name and Addr						•
	±2.		23a, Part1, Enter th	he disease, or com	plications that caused								DAIA, M	Approximate
			shock, or hear		one cause on each li	ne.	CA	OTTC	111	AID	1100	DA	1 NOG	Interval Between Cheet and Death
8	Physician /Medical		disease or condition resulting in death)		a. VIENU			UNIC	CAL	1110	VITCE.	دېب	CDOK	MC 9840
	Examiner			- 1	Due to (or as	a consequen	ce of):							
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):												
<i>-</i>	ited nsit	in in	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
	xecu and al-tra	Examiner												
260	siciar buri			l										
Box 68760,	aath certificate be executed ettending physician and for use as the burial-transit	an/Medicai												
X	nding use	N/N	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome			7				2	23d. Date of deliv	ery
_	death s ette d for	cia	in the past 12 1 Tyes 2	months?	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic pregnanc □ Other (specify) _	Э у 				Month	Day Year
Р. О.	Attending Physician: The law requires that the de rideath. sctor: Affer this certificete has been signed by the eyt the funeral director, page 2 should be detached to	Physici	9 ☐ Unknown		9□ Unknown									
	s tha	by P	Part II. Other signif	icant conditions	contributing to death b	ut not resultin	ıg in the ι	ınderiying cause gi	iven in Part	I.	23e. Did to	obacco u	se contribute to t	he cause of death?
ĕ	quire n sig uld b										1 🗆 Y	res 21	No 3 ☐ Prol	bably 4 Unknown
00	aw requir as been si 2 should	olet									24a. Was		24b. Were auto	ppsy findings available
Re	he tav e has age 2	Completed										rmed?	death?	empletion of cause of
a	ifficet or, pi	Ö	25. Was case refer	red to medical					26 Plac	o of Dooth	1 Yes		1 🗆 Yes	2 No
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ō	Phys or this oral di		27. Manner of Deat		28a. Date of Inju	ry 28	b. Time o				28d. Describe h			
on	th. : After s funers	i i	1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury		ork?]Yes 2.[]No				
Division of Vital Records,	Atter dea	fice	3 Suicide	6 Could not b	200. Flace of III	ury - At home	, farm, st	reet, factory, office	,	- 1	28f. Location (Street and Number or Rural Route Num			al Route Number,
ă	al or afte i Dire d in b	Certification:	4 Homicide		building, et	c. (Specify)					City or Tov	vn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier		nysician: To the best									
,	ne Ho ne Fu ne Fu	Medical	(Check only one)	2 Medical Exa	miner: On the basis o and manner st	f examination ated.	and/or in	vestigation, in my	opinion, de	ath occurr	ed at the time,	date and	place, and due t	o the cause(s)
	Withir To the To the Comp	ž	29b. Signature and	title of certifier					se number				te signed (Month,	
			•	111				01	85	45		10	LY 22	5, 2011
	5		30 Name and d	ss of person who	completed cause of o	leath (Item 23	а) (Туре	Print)	100	200	1110	NOI	E Idal	78/075
			Y. 6019	501344	del-0 /2	2070	EL	1) UNE	(EA	18/	WHI	KIL	7 1609	28602
	Sta	te	31. Date filed (Mon. AUG 0 4	th, Day, Year)	32. Registr	ar's Signature	9						/	
	Registr	ar	MUID II 4	/1111 /2		The second								

Registrar

P.O.

Division of Vital Records.

Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Reg. No. 2 Date of Death Physician/ July 2019 JOHN FRANCIS FISCHER 4:50 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 ₩ M 2 □ F Year 920 Days Hours Min June 20 Mary Land 217-10-0180 91 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Culler Avenue 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. WWII Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Binding Foreman Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Fischer Margaret V. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Fischer / Son 8225 Glendale Drive, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 7/18/2011 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Libersee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Fait E 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final ATHERO SCLEROSIS Onset and Death DISEASE Coronary Antery disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death Unknown Ectopic pregnancy in the past 12 months? Month Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes completed filled in by the funeral director. 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause (s) and manner as stated to the cause (s) and place, and place, and place and pla Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47951

Registrar DHMH 17 Rev 7/2009 Toll House

AUE.

+REDERICK

MD

32. Registrar's Signature

ButREAM

814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IBLE A KAZMIMO

31. Date filed (Month, Day, Year)

07-15-2011

21701

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2011 Ge1b June 2:30 Miriam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Spring <u> Althea Woodland Nursing Home</u> ilver 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 M 2 X F Months Days Hours Min. 100 Yrs. Director Pennsylvania 06/01/1911 170-10-8725 Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified 1 X Yes 2 □ No MD Kensington Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3618 Littledale Road 20895 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ည Henry Levine Lena Shultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 1916 Flowering Tree Ter. Silver Spring, MD 20902 Lenore Gelb / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 9 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State injury (4 ☐ Donation 5 ☐ Other (Specify) 07/03/2011 Lebanon Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD any <u>Blake</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Fredure CI with C Physician/ disease or condition resulting in death) DENS mo omt Medical Due to (or as a consequence of) . Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and ne burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician the buria Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ g g ☐ Unknown 9 Unknown ğ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by O Stevan Invitis 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Diabetes mellitus Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No ANE MIA or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗌 No Other: 1 X Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred ☐ Natural

X Accident 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun Je// Unt 2 X No 15 2011 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Reyrament Common 28f. Location (Street and Number of Rural Floute Number, City or Town, State) 36/5 L 1977 County Number, City or Town, State) 4 Homicide determined Kensington MO Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, **Division of Vital**

> State Registrar

29b. Signature and title of certifier

ean

DeVore M.D.

un

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

4203 Queensbury Rd. Hyattsville, MD 20781

D01852

29d. Date signed (Month, Day, Year)

June 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. N.20 24892 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 7:15 A M William Alexander Garner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Catherine's Nursing Home Emmitsburg Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 1 Months Hours (Month, Day, Y Mary Land 90 1921 Director 217-16-2360 May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2X No Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral United States 16515 Old Emmitsburg Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. and Mental Hygiene. is marked other than "natural", Completed 3 Divorced 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Statistician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EMily Agnes Taylor William Alexander Garner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21727 portant: If item 27 is rinjury or other trau Elizabeth Garner / Wife 16515 Old Emmitsburg Road Emmitsburg, Maryland 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Stauffer Crematory Frederick, Maryland 21. Signa vire of Fu Stauffer Funeral Homes, P.A. et Thurmont, Maryland 21788 any 7/65 E. Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause and ling of the death. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ OMM disease or condition Medical resulting in death) Due to (or as a pinsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? page 2 this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Accident injury 5 Pending work 1 Yes 2 No 24 hours after death Funeral Director: A Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Ceftifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I

10 + 1 VA

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Carroll, M.D. 310 S. Seton Avenue

Emmitsburg, Maryland 21727

29d. Date signed (Month, Day, Year,

l

31. Date filed (Month 18 2011 32. aistrar's Signatur

State Registrar 29c. License numbe

0018705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Gill Medical Facility Name (if not institute tion, give street and number Examiner County of Death comico oasta . Age (In yrs. last birthday) 73 vre 8. Date of Birth If Under 1 Year If Under 24 H 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours 219-70-1882 11/15/1937 England Director Yrs. Usual Residence of Decedent or 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 1 🗌 Yes 2 🕱 No Maryland Somerset Westover 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be or items 23a 7777 Clyde Ford Road 21871 England 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. 1 K Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Il Hygiene. other than "natural", Specify: 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Doctor Health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည William Cameron Mary Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Dorothy Brown/POA 402 Market St., Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 7/20/2011 Salisbury Crematory Salisbury, MD Holloway Funeral Home Professional Association 0 ance CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only age cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DAAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year n signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/1 No 1 🗌 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1.24 hours after death.
e Funeral Director. After this certificate has letted filled in by the funeral director, page 2 : autopsy performed 1 Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 😂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

31. Date filed (Month, Day, Year)

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 2. Date of Death Physician/ July James R. Gross Jr 2011 2145 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Aug 31 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F ^{Year}1967 Maryland **Director** 217-94-7911 43 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Mary1and Anne Arundel Churchton 1 🗆 Yes 2 🗶 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1141 Deep Cove Rd. 20733 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: B1ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Waterman Self Employed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ewe ည James R. Gross Sr Patricia Nick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gross(Mother) 1141 Deep Cove Rd. Churchton, Md. 20733 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Hope St. Mark UMC 1 X Burial 2 Cremation 3 Removal from State 7-16-11 Edgewater, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Miniame are essent Facilitisons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1tr cours Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy pade performe 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ Impatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 1m 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

192011

Box 68760

P.O.

Records,

Division of Vital

11-05291 Peter Gavian Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Peter Gavian		Sta	ate of Maryla	nd / De	partme	ent of Hea	Ith and N			20		24895		
		- For State Registrar	1 0		ertifica	ate of Dea	th		2. Date of Deat	g. No.		2. Time of Dooth		
Physician Medical Examina	4	1. Decedent's Name (First, Middle							Month July 16, 20	Day Yea	r	3. Time of Death 0037 hrs		
		PETER WOOD GA' 4a. Facility Name (if not institution Arunde I Arunde Medica	n, give street and nu	mber)	-		Town, or Loca	ation of Dea		4c. County of				
7							apolis			Anne Ar				
Funeral Director			6. Sex	7. Age (In yr		Mont		Under 24H Hours Mi	n.	th (MM/DD/YYYY	Foreig	hplace (State or n		
Billector	-	026-24-0897 Usual Residence of Decedent	1 X M 2 F		78	Yrs.			12/08/	1932	Col	untry) MA		
any	-	10a. State 10b. County		10c. C	ity, Town	or Location						10d. Inside City Limits		
show are	5 I	MARYLAND ANNE	ARUNDEL	A	NNAP	OLIS						1 X Yes 2 No		
Maryland 28a-f show	ğ	10e. Street and Number		•		10f. Zi	p Code		10	g. Citizen of Wh	at Cour	itry?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiens Mattural", or items 23a or 28a-f sho importaot: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	782 FAIRVIEW A					403			USA		Disale		
ath wi	, je	11. Marital Status 1 Never Married 2 Ma	rried Armed Fo	orces?	unk				Specify Yes or No- to Rican, etc.)	- 14. Race White		can Indian, Black,		
fter de		3 Widowed 4 X Divo	1 X Yes orced If Yes, Give Yea	2 ∐ No r	0	1 Yes 2	∑ No sp	ecify:		Specify:	WHI	тЕ		
ours a	핡	15. Decedent's Education (Spec	ify only highest grad	le completed) 16a. I	Decedent's Usual during most of wo				16b. Kind of Bu	siness/l	ndustry		
16 n 72 h		Elementary/Secondary (0-12)	College (1	-4 or 5+)					in out					
J with J with grene.	Completed	17. Father's Name (First, Middle,	Last)	+		SECURITI	ES ANA 18.M	LYST Nother's Nam	e (First, Middle, N	FINANO Maiden Surname				
21215-0036 build be filed within 7 Montal Hygiene. marked other thao	86	SARKIS PETROS							ILLICENT					
D 21 nould I is mar		19a. Informant's Name/Relationsh	ip (Type, Print)		19b	. Mailing Addres			Rural Route Num		n, State	Zip Code)		
MD and 2 sho alth and 2 sum 27 is raumati	-	DEBORAH COSTOL	LOE/DAUGH	TER		5 STANTO			OKLINE,	MA 02445 20c. Location -		Town State		
Ore, of He tite the		1 Burial 2 X Cremation	3 Removal fro	04-4-	cremate	ory or other place	1	NNT						
Baltimore, permit. Pages I a Department of He Important: Wittining or other tinjury or othe	ŀ	4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:	CHESAPEAKE CREMATION 07/				/19/2011 STEVENSVILLE, MD						
Derm Depa Impo		HELFENBEIN & NEW								ASTING TRIBUTES BY FELLOWS, NAM CREMATION S. FUNERAL CARE, E ROAD, ANNAPOLIS, MD 21401				
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that co	aused the dea	ath. Do no							Approximate Interval Between Onset and		
/Medical Examiner	1	Immediate Cause (Final disease	a. Hypertensiv	e Atheros	sclerotic	Cardiovascu	ular Diseas	se				Death		
		or condition resulting in death)	Due to (or as a	consequenc	e of):									
	9	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequenc	e of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a	consequenc	e of).									
xecuted		events resulting in death) Last	d.	consequence	C 01).									
Cial Cial	eg -	UNPENDED	X AMENDED	4a,per	me,	g918 8-1	17-11 s	sm						
Box 68760, e death certificate be the attending physici ed for use as the burn	욹	IF FEMALE: 3b. Was decedent pregnant in the		outcome of pr						23d. Date of	-			
K 68	Clar	past 12 months?	I TIME D	ιπη ant at time of	death 5	=	_	ctopic pregr	iancy	Month	L	ay Year		
BO) e death the att	<u>s</u>	1 Yes 2 No 9 Unk	9 Olikiic	own										
Records, P.O. Box The law requires that the death care has been signed by the after page 2 should be detached for r	by P	Part II. Other significant conditi	ons contributing to	death but no	ot resulting	in the underlying	g cause given	in Part I.			_	the cause of death? ably 4 Unknown		
quires en sign		Chronic Alcoholism				_			24a. Was a			topsy findings available		
COFC	ᇍ								autop: perfor	sy p m <u>ed</u> ? d		ompletion of cause of		
	To the second s								s 2 No					
Division of Vital Records, P.C. spital or Atteoding Physician: The law requires that tours after death. soral Director: After this certificate has been signed filled in by the funeral director, page 2 should be deter	ň	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 1	npatient 2	✓ ER/OL	Itpatient 3	DOA Othe	Sr. —		Residence 6	Other			
of N	앍	27. Manner of Death	28a. Date	of Injury Day,Year)	28b. 1	Time of Injury	28c. Injury at	Work?	28d. Describe h	ow injury occurre	ed	·		
ion tteodii tor: /		1 Natural 5 Pend 2 Accident Inves		,,,			1 Yes	2 No						
IVIS lor At after d Direc	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - A	t home, fa	rm, street, factor	y, office buildi	ng, etc.	28f. Location (S or Town, S		er or Ru	ral Route Number, City		
		4 Homicide 29a. Certifier	(0,000,17)	1 of m. los a		the annual at the	- time data a		d due to the sour	a/a) and manner	ac state			
Division of Vital To the Etopital or Attrecting Physician: within 24 hours after death. To the Fuoreal Director - After this certif completely filled in by the funeral director.	ल	(Check only	ysician: To the bes	of examination				-						
To wit	ĕ -	29b. Signature and title of certified	and manner s	ated.		29	c. License nu	mber		29d. Date signe	ed (Mor	nth, Day, Year)		
7.		1/11 -		137			O.C.M.E			July 16, 20	11			
4. KX.	ŀ	30. Name and address of person					=			200004				
		Russell Alexander MD				900 W. Ba	Itimore Str	eet, Balti	more, MD 212	2230CME				
Sta Registra	te ar	31. Date filed (Month, Day, Year)	2011	gistrar's Sign	ature.	back	1							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 16, Day 2011 Year Physician/ 10:50P. M Roy Hoppe Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring ..County of Death Prince George's Examiner Renaissance Gardens at Riderwood Village If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 ☐ F Hours Feb. 182, 1926 Michigan 85 **Director** 369-20-6745 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 3160 Gracefield Road, #EV2219 20904 United States Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces?
X Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 0/4-1968 Year or Dates. 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meteorologist Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julia Bonikowski John Hoppe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hoppe -son 12604 Blackwell Lane Bowie, Maryland 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arlington National Cem. 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 11/3/2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, PA 4400 Powde<u>r Mill Road Beltsville, Maryland 20705</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final 10 Vears Physician/ Chronic Kidney Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Diabetes Type II Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 型 that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The law requires the funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial. Division of Vital Records, P.O. Box 68760

State

Certificate:

Medical

1 Natural

2 Accident

3 Suicide 4 Homicide

only one)

Signature and title of certifier

Eileen Gemmell. 31. Date filed (Month, Day, Year,

JUL 21 2011

29a. Certifier

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

6 Could not be

Registrar DHMH 17 Rev 7/2009 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3160 Gracefield Road Silver Spring, Maryland 20904

158667

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | 24897 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 18, Loretta Hinitz 2011 10:30p ^M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9202 Topeka Street Montgomery Bethesda Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Min (Month, Day, Year) 11/01/1922 129-01-0675 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20817 9202 Topeka Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) National Naval Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center Tumor Registrar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Myerson Minnie Weisburger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis H. Satterfield/Daughter 9706 Brixton Lane Bethesda, Md. 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Arlington National Cemetery 7/21/11 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility Edward Sagel Funeral Direction M00910 Rockville Pike Rocky 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pulmonary Hypertension disease or condition resulting in death) Due to (or as a consequence of):

Physician Medical **Examiner**

permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once.

Physician/

Medical

10a. State

Md.

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

f show

Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Fant, If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit Completed by Physician/Medical Be ျပ Certificate:

Medical

(Check only one)

29b. Signature and titte of certific

Bret Pasiuk

JUL 21 201

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 center Drive

signed by the a

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director, After this certificate filled in by the funeral director,

completed

Division of Vital Records, P.O. Box 68760

	Chronic Obstructive Pulmonary Disease								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to for as a conseq	uence vij.							
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 Dectopi	ic pregnancy (specify)		23d. Date of delivery Month Day	Year			
Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	o use contribute to the cause	of death?			
Chronic K	idney Disease	44		1 🔀 Yes	2 ☐ No 3 ☐ Probably 4	↓ ☐ Unknown			
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☒		of cause of			
25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)					
1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 🕅 Residence	6 ☐ Other (Specify)				
27. Manner of Death 1 🖼 Natural 5 🗌 Pending 2 🗒 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?			28d. Describe how inj	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 X Certifying Physic (Check 2 Medical Examin	ician: To the best of my knowner: On the basis of examination	rledge, death occured on and/or investigation,	at the time, date and place, a	and due to the cause(s) at the time, date and pla	and manner as stated. ce, and due to the cause(s) and	d manner stated			

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

 m_D

29c. License number

Bethesda, Md. 20892

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ July 5:00 A. M Rudiger Dieter Haugwitz 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 XM 2 - F Hours April 4, 1932 532-38-4822 79 Director Germany Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5905 Greenlawn Drive 20814 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Specify:White 1 Yes 2 No Specify: If Yes, Give 3 - Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Chemist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Haugwitz Helene Galinat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malin Haugwitz/Daughter 5905 Greenlawn Drive, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Georgetown university 18 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2011 4 Donation 5 Other (Specify) Medical Center Signature of Funeral Sen 22. Name and Address of Facilit Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph.sician/ Intracerebral Hemmorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Vear 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? 1 ☐ Yes 2X No To the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 🔼 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify HOSPICE this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) D37142 July 18, 2011

Registrar
DHMH 17 Rev 7/2009

State

Z

1355 Piccard Drive Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Geoffrey Coleman,

JUL 2 1 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 | |

24899

			State Registrar		Cert	tificate of E	Death		Reg. No.		
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
	Physicia Medio		WILLIAM EARL HARRIS,	SR.				07/1	7/20		5:35p ^M
	Examin		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or	Location of Death	1	4c. 0	County of Death	
·E			Holy Cross Hospital	L		Silver S			Mor	ntgamer	7
	Funeral Director		238-70-1292	M 2 ☐ F 7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 11/9/4	, Year)	9. Birth Cour NC	place (State or Foreign ntry)
	nd now	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits
	arylar a-f sl	Director									1 🎛 Yes 2 □ No
	or 28	ä	MD Montgomers 10e. Street and Number	Z Silver	r Spr	ng 10f. Zip Code			10a. Citiz	en of What Cou	ntrv?
	/ith th	ra							3		,
	ath w	Funeral	14434 Bel Pre Drive	2. Was Decedent Ever in U.S.	13. W	20906 as Decedent of Hi	spanic Origin? (Sp		$J.S_{-1}$	4. Race - Ameri	can Indian,
(0	er de or it	by F	1 ☐ Never Married 2 🍱 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Yes, specify Cuba		o Rican, etc.)		Black, White,	etc.
ğ	s aft ral", Exal	ed k	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	Yes 2 No	Specify:	n	s	pecify: Bla	ick
2-0	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade			ent's Usual Occupi ind of work done o		kina	16b. Kin	d of Business Ir	ndustry
21215-0036	iin 72 ie. han '	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife. DO	NOT use retired)		ning :			
21	d with	(D)	7th		Windo	w Cleane					Service
pu	e filec Ital H ed ot ever	0	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Si	urname)	
3	uld bu I Mer nark	-	Alfred Harris				Alberta				
Maryland	2 should h and Me 7 is mar traumati		19a. Informant's Name/Relationship (Type			g Address (Street a Bel Pre					
	and 2		Peggy Harris/wife 20a. Method of Disposition			ition (Name of	101.1011	Date Deta	_	ation - City or T	
Baltimore,	nt of h		1 🔀 Burial ∕2 🗀 Cremation 3 🗆 R	emoval from State ceme	eterly, cliem	atory or other plac				•	
턆	iit. Pa urtme ortan njury	- 3	4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur • f F ineral Service Liversee	7 // Gate	of He	eaven Name and Addres		25/20±1			ng, MD
Ba	permit. Page 'Department o' Important: If any injury or once.		21, Signatura mineral Service Engage	La mode	7.3.17	6 N. Was					20850
			23a. Part 1. Enter the disease, or complic	ations that caused the death.	-					10, 12	Approximate
	01	١.	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		,		, ,			Interval Between Onset and Death
-	Physician/ Medical		disease or condition resulting in death)	Stage 4 Prost	ate C	ancer_				- 1	
and the	Examiner		(Sepsis	ce oi):						
7		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	ce of):						
	E 50	Examiner	cause. Enter Underlying	Cardya Pulmon	narv	Arrost					
	n and		that initiated events c. resulting in death) Last	Due to (or as a consequence		HICOC					
0	certificate be executed nding physician and use as the burial trans	Medical	d.					_			
68760	ficate g ph) as the	Ved									
	certi		200. Was decedent program	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de		Ectopic pregnance	24		2	3d. Date of deliv	very
P.O. Box	death cer e attendi d for use	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of deat		Other (specify)	у			Month	Day Year
<u>.</u>	the c by th tache	چ	g □ Unknown								
	v requires that the death cert been signed by the attendir should be detached for use	Completed by Physician	Part II. Other significant conditions cont	ributing to death but not resulting	ng in the ur	nderlying cause giv	en in Part I.				the cause of death?
ds,	quire; en siç ould b	ted	Severe Hypokalemia					1 🗆 '	Yes 2	No 3 ☐ Pro	obably 4 😾 Unknown
Sor	aw re as be 2 sho	ple						24a. Was autop			opsy findings available ompletion of cause of
Ä	The la ate h	ő						perfo 1 ☐ Yes	rmed?	death?	2 😾 No
E	sian; ertific ctor,	Be	25. Was case referred to medical examiner?				ace of Death (Che	ck only one)			
5	hysic his ca il dire	မ	1 ☐ Yes 2 🙀 No	spital: 1 Inpatient 2 I ER			4 D Nursing F	łome 5 ☐ Resig	lence 6	Other (Specif	ý)
J O	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury	occurred	
ion	tendi Jeath tor: A the fi	iţi	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 ☐ No				Ta
Division of Vital Records,	or Attending Physician; The law requires that the death after death. Director: After this certificate has been signed by the atte in by the funeral director, page 2 should be detached for in by the funeral director, page 2.	Certificate:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Hura	al Route Number,
	pital ours a eral [200 Cartifier 1 Thomas friend Physics	are To the best of my knowledge	an doath o	sourced at the time	data and place of	and due to the car	uso(s) and	manner ac stat	ed.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has Yompleted filled in by the funeral director, page 2	Medical	(Check 2 Medical Examine	an: To the best of my knowledger: On the basis of examination and Practioner: To the best of my kn	nd/or investi-	gation, in my opinio	on, death occurred	at the time, date a	nd place, a	and due to the ca	ause(s) and manner stated.
	othe othe	Σ	only one) 3 L Certifying Nurse	Practioner: To the best of my kn	iowieage, a	29c. License				signed (Month,	
	559		1, Inio A	2620	7	NO	040	162	07.	-17-	2011
			30. Name and address of person who con	pleted cause of death (Item 23	(Type, Pr	rint)	000	04			9.0
			Edith Nebuwa Anledo				lver Spr	ing, MD	2091	0	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	ba						
	Registra		.## 21 2011	May D.	AM	Acres V					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ ^D2011 Mary Merle Harmon 20 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Marbury Charles 5600 Bicknell Road 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye 1 🗆 M 2 💢 F Months Days Hours Min ^(ear)1920 Country)
Maryland Director 91 220-28-6416 Jan. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles 1 Yes 2 No Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5600 Bicknell Road 20658 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Franklin Unknown other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Quinlan Niece Md. 20658 5600 Bicknell Rd., Marbury, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2011 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Funeral Service 21. Signature of Funeral Sen Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest a failure. List only one cause on each line. 23a, Part 1, Enter Approximate Interval Between Onset and Death shock, or neart failu Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co A quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 70 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) Nieces within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2//11 D21031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 71310 12070 old line Center 302 Waldorf Suite mp 20602 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MECHAL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24901 State of Maryland / Department of Health and Mental Hygien 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Month} 18 − 2011 18:48pM Holland Jr. Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George 9112 Lincoln Upper Marlboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday 12-22-1946 Maryland 215-44-4605 64 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Upper Marlboro <u>MarylandPrince George</u> 10e. Street and Number 10g. Citizen of What Country? USA 20774 9112 Lincoln Ave 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 No Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Controller 12 Quality Safeway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Holland Sr <u>Antoinette</u> Easton <u>Thomas</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darcy Rd, Upper Marlboro MD 20774 Lois Holland / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 7/26/11 21. Signature of Inneral Service Licensee 22. Name and Address of Facility Adams Funeral Home, PA, Aguasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) IF FEMALE. 23b. Was deced in the past Yes 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery regnancy Pregnant at time of death 1 L Yes V 2 E q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Ph sician/ Medical Examiner

> -transit and

attending physician a for use as the burial-

signed by the a

certificate has

filled in by the funeral director,

within 24 hours after death.

To the Funeral Director: After this

Box 68760

P.O.

Division of Vital

Physician/Medical

Completed by

Be

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Certificate:

Physician/

Medical

Examiner

Funeral

Director

28a-f show

23a

"natural", or items

injury or other traumatic event, the Medical

and Mental Hygie is marked other

item 27

Department of H Important: If ite any injury or ot

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

must be notified at

Director

Funeral

Completed by

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

2 No 3 Probably 4 Unknown 1 Yes

24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death

Hospital: 1 Inpatient 2 Aroutpatient 3 DOA 28a. Date of injury 28b. Time of (Month, Da

building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury of

26. Place of Death (Check only one)

perform

2 No 1 Yes

Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined

28e. Place of Injury - At home, farm, street, factory, office

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check 29b. Signature and title of certifier

29a. Certifier

Gertifying Nurse Practioner. To the best of my knowledge, death continued of the littin, date and plant, and due to the relievely but marrier as state

Registrar

se of death (Item 23a) (Type, Print)

		T = For State Of Wild Registrar	aryland / Depa <i>Cer</i>	artment of Hea tificate of Dea	ilth and Mental F ath	ayglene 201	1 24902
Physic		1. Decedent's Name (First, Middle, Last) Fau ELiza	beth Jackso	on	2. Date of Month Jul		3. Time of Death 6:55pm
Exam	lical iner	4a. Facility Name (if not institution, give street and number) Kline House		4b. City, Town, or Loca		4c. County of D	eath rederick
Funer			e (In yrs. last birthday) 97 Yrs.	If Under 1 Year If U	Jnder 24 Hrs. 8. Date of	Birth g. I	Birthplace (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation	June	28,1914	10d, Inside City Limits
Marylar 28a-f st otified	irecto	Maryland Montgomery	1001 010, 101111 01 200	Silv	ver Spring		1 ☐ Yes 2 🂢 No
with the s 23a or ust be n	Funeral Director	10e. Street and Number 3210 N. Leisure World Blv	d., #417	10f. Zip Code	0906	10g. Citizen of What	.S.A.
Iryland 21215-0036 ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	_ ≥	a Diversed II fes, Give	No If	Vas Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No- 14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
15-0C 72 hours "natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation kind of work done during	g most of working	16b. Kind of Busine	ss Industry
212- 4 within 7 ygiene. her than it, the M		Elementary/Seconday (0-12) College (1-4 or 5	+) life. DC	O NOT use retired) Clerk		Milit	
Aaryland should be filec and Mental H 7 is marked ot	To Be	17. Father's Name (First, Middle, Last) Lee Richard		18.	Mother's Name (First, Mid-	dle, Maiden Surname) Sie Beatty	
nore, Marylar ge 1 and 2 should be 1 nt of Health and Ments t: If them 27 is marked or other traumatic e		19a. Informant's Name/Relationship (Type, Print) George Ralph Jackson - Spou	l e	-	Number or Rural Route Nur World Blvd.		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important If item 27 is marked other than "natural", o my injury or other traumatic event, the Medical Exam		20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 2 🗆 Removal from State 4 🗀 Ponation 5 🗀 Other (Specify)	20b. Place of Dispos	sition (Name of natory or other place)	Date 07/23/2011	20c. Location - City	or Town, State
Baltimo		21. Signature of Frineral Service Licensee	22.	. Name and Address of	FacilityHines-Riv	ialdi Funera	L Home, Inc. ing, MD20904
z.		23a. Fart 1. Enter the disease, of complications that caused shock, or hear failure. List only one cause on each line Immediate Cause (Final	the death. Do not ente		·		Approximate Interval Between Onset and Death
Physician Medica Examine	al	disease or condition	consequenc of):				Years
_ A		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):				
760 cate be executed physician and s the burial massin	Examiner	Cause (Disease or impury that initiated events resulting in death) Last C. Due to (or as a	consequence of):				
760 icate be physicials the bur	ledical	d					
Records, P.O. Box 68760 The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial track.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	of pregnancy 2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)	_	23d. Date of Month	delivery Day Year
ds, P.O. quires that the en signed by t culd be detach	2	Part II. Other significant conditions contributing to death be	ut not resulting in the ur	nderlying cause given in		id tobacco use contribute	to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. W a p 1 □ Y	utopsy prior t erformed? death	autopsy findings available to completion of cause of ? Yes 2 \(\sum \text{No} \)
ision of Vital Attending Physician: Frideath ector: After this certific by the funeral director,	To Be		ent 2 ER/Outpatien	Othori	of Death (Check only one) Nursing Home 5 R	esidence 6 Other (Sp	necify) Hospice
on of anding P ath. r. After t	Certificate:	27. Manner of Déath 1 Natural 5 Pending (Month, Day) 2 Accident Investigation	y 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes		e how injury occurred	
JIVISI al or Atte s after de I Directo		3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office		n (Street and Number or i Town, State)	Rural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has prompleted filled in by the funeral director, page 2 is	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Medical Examiner: On the basis of examiner: To the last of examiners are considered.	camination and/or investi	igation, in my opinion, de	eath occurred at the time, da	te and place, and due to th	ne cause(s) and manner stated.
To # Virthi		29b. Signature and title of certifier	1)	29c. License num	nber	29d. Date signed (Mo	nth, Day, Year)
		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	rint) Frede	CXY M	2170)
St Regis	ate trar	31. Date filed (Month, Day, Year) 62. Registra	r's Signature		(())	1 4 100	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ 4:10am Kimball Ruth Smith 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 □ M 2 🗓 F 12 /0.2 New Jersey 77912 138-30-9356 98 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 X No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20850 9102 Darnestown Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Public Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Defamile Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or our Edward Smith Mary Tomlinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Kimball Peloquin/Daughter 9102 Darnestown Road, Rockville, Maryland 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory at Loudon Park 1 Burial 2 X Cremation 3 Removal from State 07/21/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee 1232 tenter, 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Debility disease or condition Medical resulting in death) Due to (or as a consequence of): ml Examiner Electrolyte Disorder Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Obstruction of Ureter and Due to (or as a consequence of) resulting in death) Last 20 attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Physician/Medical Abnormal Aortic Aneurysm Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sacral Fracture 1 Yes 2 No 3 Probably 4 X Unknown Atter this certificate has been si funeral director, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 🕅 Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 X Accident 5 Pending Fell at Daughter's Home 05/10/2011 10:00 pm 1 Yes 2 🕱 No Investigation eampleted filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 9102 Darnestown Rd., Rockville Daughter's Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 18. 2011 D37142

Registrar

State

1355 Piccard Drive, #100, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman, M.D.,

JUL 21 2011

State of Maryland / Department of Health and Mental Hygien ? 24904 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:00 PM Physician/ Month July 2011 Shalom Kanovsky Medical Yaakov 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard <u>Lorien Nursing Home</u> Columbia . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Min. 10/22/1947 Country) Israel Director 63 094-36-8593 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 X Yes 2 No Kings Brooklyn NY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1138 52nd Street 11219 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No If Yes, Give 3 Widowed 4 Divorced "natural" Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Legal Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tamar Parnes Eliyahu Kanovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 1607 S. Springwood Dr. Silver Spring, MD Cahnoch Kanovsky 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State cemetery crematory or other place)
Eretz Hachaim
Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beit Shemesh Israel 7/18/2011 21. Signature of Funeral Service License 22. Name and Address of Facility
Edward Sagel Funeral Direction
1091 Rockville Pike Rockville Inc. MD 20852 Blake 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SERSIS disease or condition Medical resulting in death) **Examiner** ENCEPHALOPATHY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events MYOCARDIAL INFARCTION Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical ATHEROSCLEROSIS Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ò in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC KIDNEY DISEASE 24a. Was an autopsy the Hospital or Attending Physician: The nin 24 hours after death. the Funeral Director: After this certificate in pleted filled in by the funeral director, page FIBRILLATON ATRIAL Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Iniury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24
To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 264395 JULY 16. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DOBERMAN, MO 31. Date filed (Month, Day, Year) State

Registrar

JUL 21 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 240 PM Erma McDougal Keetley 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hartord NOBING Citizens Home favre De Grace If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-14-7741 1 □ M 2 🂢 F Months Hours Min. $(\text{Month }\mathcal{D}^{\text{ay, Year}})$ Maryland 90 May Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. tem 27 is marked other than "hatural". or iteme 99, n-90, f-1-1 10d. Inside City Limits 10a. State 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Funeral Director 1 X Yes 2 No Cecil Port Deposit Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 80 South Main Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces
1 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 🕅 Widowed 4 🗆 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Cecil County Court and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House Marriage License Bureau Twelve Years Maryland permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amelia Campbell Wilson McDougal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 South Washington St., Havre de Grace, MD 21078 Kenneth W. Keetley (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Angel Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 07/23/11 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Sign wure of Funeral Service Licenuhomas m. + cuter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4X Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: iniury work? 1 Natural 5 Pending 2 No hours after death. Ineral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day

render

30. Name and address of person who completed cause

cetie

death (Item 23a) (Type, Print)

32. Reg

29d. Date signed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene [] = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2011 Paul Harry Lambert 8:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 🕅 M 2 □ F Months Days Hours Min. Mary Land Yrs Director 214-34-5248 74 May Usual Residence of Decedent 10d, Inside City Limits within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 23a or 28a-f shust be notified 1 🗆 Yes 2 🔀 No Frederick Maryland Frederick 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23/ edical Examiner must USA 21701 10223 Lenhart Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation 15, Decedent's Education 16b, Kind of Business Industry hand Mental Hygiene.

7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dairy Farmer Farming Be Page 1 and 2 should be filed ment of Health and Mental Hy, ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul W. Lambert Cora Blubaugh traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10223 Lenhart Road, Frederick, MD 21701 Esther Lambert / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/15/2011 Thurmont, Maryland St. Paul Utica 21. Signa re of Funeral Service Licenses Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 ase or complications that cause Ust only one cause on each Part 1. Enter the disea shock, or heart failure the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition PROBABLE COPD Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? For Day Year Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 K Unknown Records, Hospital or Attending Physician: The law requires Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner? Other: 2 1 No 1 Yes မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending work 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7114 11 MDD 71068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Sathyabama Naidu

400 gistrar's Signature 74h St

Frederick

wy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 201 0133 Mckar 07 Saban Medical 4a. Facility Name (if not institution, give street and nur 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 / 1 8 / 9. Birthplace (State or Foreign Country)
DC 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Hours Director 579-46-4810 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Silver Spring 1 Yes 2 X No Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 1580 East West Hwy Apt 134 20910 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Š Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ഉ Virginia Catlett Conrad Gravely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 W. Main St., Middletown, MD 21769 19a. Informant's Name/Relationship (Type, Print) Lucie Smith (Daughter) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Bury XXcremation 3 D Removal from State Smithsburg Crematory 7/16/2010 Smithsburg, MD 4 Denation 5 Sther (Specify) Signature Innera Sirvice Licensi 22. Mona Maries B. Facili Thompson Funeral Home POB 18, Middletown, MD 21769 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SIPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Nomel Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) signed by the attending physician and a be detached for use as the burial-transit Cause (Disease or iinjury mu that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be whin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2: autopsy performed 1 Yes 2 No 1 🗌 Yes 2 🗷 25. Was case referred to medical 26. Place of Death (Check only one) examinera 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 72130 14/2011 ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Lastry

Janus 31. Date filed (Month, Day, W

8 2011

Registrar's Signature

South

Grene Street

Bultimon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 24908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Arthur Paul Mayer, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Regional Hospital Prince (seorge aure 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 3, 1959 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 222-52-1667 1 ★ M 2 □ F 52 Director DE Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland all Hygene. d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park MD Montgomery 1 Yes XX No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20912 7311 Piney Branch Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bubble Production Specialist CHI Center Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elisabeth Jane Callahan should be file 2 Arthur Paul Mayer, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7311 Piney Branch Road, Takoma Park, MD 20912 and 2 s Health Constance M. Mayer/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of July 21, 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. ŏ cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2011 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Litter the disease, or complications that causes are death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Septic Physician/ Medical resulting in death) Examiner Aspiration Theymonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last rood ed by the attending physician detached for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome 1 Yes 2 No 3 Probably 4 Unknown Alzheimer's Dementid 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform this certificate 2 X No 1 ☐ Yes 2 X No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director. After this of Completed filled in by the funeral director. 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending food July 14, 2011 1230 2 - NO Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 7311 Pines Brand, Silver Sports, A Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 17, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road Gaji. MD Laurel Regional Nega

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

		•	State Registrar		C	ertificate of	Death		Reg.	No.		
	Dhysicis	n/	1. Decedent's Name (First, Middle, La	st)				2. Date of	f Death	Day Yea	3. Time of Death	
Н	Physicia Medic		Ralph Wilson Mc					2. Date of Month	07 2	2 ^{Day} 2011	1:36 A	M
	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town,		of Death		4c. County of De	eath	
			Smith Creek Ass 5. Social Security Number 6.5		ng e (In yrs. last birthda	Warwic		24 Hrs. 8. Date of	f Righ	Cecil	Birthplace (State or Forei	ian
	Funeral Director			1 X M 2 □ F	92 Yrs	Months Days			, Day, Yea 28/19	918	Country) MD	911
	and show at	ا ة	10a. State 10b. County		10c. City, Town o	Location					10d. Inside City Limi	its
	Maryla 18a-f	Director	MD Cecil		E1kton						1 □ Yes 2 😾	No
	the land		10e. Street and Number			10f. Zip Code			10g.	. Citizen of What	Country?	
	h with	Funeral	841 Leeds Road			21921				USA		
	deat riten iner		11. Marital Status 1 Never Married 2 Married	12. Was Decedent 6 Armed Forces?		 Was Decedent of If Yes, specify Cul 	Hispanic Orig oan, Me xican	gin? (Specify Yes or n, Puerto Rican, etc.	No-)	14. Race - Ar Black, W	merican Indian, hite, etc.	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	1 🔀 Yes 2 🗌 If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 N				Specify: W]	nite	
15-	72 ho n "na"	ag e	15. Decedent's E (Specify only highest g	rade completed)	(G	ecedent's Usual Occu ive kind of work done e. DO NOT use retired	during most	t of working	161	b. Kind of Busine	ss Industry	
712	vithin iene.		Elementary/Seconday (0-12)	College (1-4 or 5	D+)	ryland Sta	′	ttery		State Go	vernment	
ď	filed wit tal Hygie d other event, th		17. Father's Name (First, Middle, Last)				T	er's Name (First, Mic				
/lar	ould be fil nd Mental marked matic ev	잍	George Washingt	on McCool			Mari	ion Smith				
lan	shoul and is m		19a. Informant's Name/Relationship (Type, Print)	19b. N	lailing Address (Stree	t and Numbe	er or Rural Route Nu	ımber, Cit	y or Town, State,	Zip Code)	
رب ک	of Health and Ment fitem 27 is market rother traumatic		Emma Grace McCo	ol - wife		Leeds Ro	ad, El					
Baltimore,	ge 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery,	isposition (Name of crematory or other pl	ace)	Date		c. Location - City		
Itin	permit. Page 1 a Department of F Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Line	ify)	Bethe1	Cemetery 22. Name and Add	nea of Coollit				te City, MD	
Ba	permi Depar Impo any ir once.		21. Signature of Puneral Service	1	,	259 East					Home, PA	
			23a Part 1. Enter the disease, or com	plications that caused	the death. Do not					,	Approximate	
	Physician/	8	shock, or heart allure. List only the shock of heart allure. List only the shock of	/.	em,a						Interval Between Onset and Death	
	Medical		resulting in death)	a	a consequence of):							
	Examiner	<u>.</u>	Sequentially list conditions,	b								
	d sit	ie	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):							
	and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
0	rificate be executed ing physician and as the burial-transit			• d								
8760	ficate g physis the	Medical		- u								
9	death certii he attending ed for use a	ı 🥆 I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregna	ncy			23d. Date of Month	delivery Day Year	
P.O. Box	equires that the death cer een signed by the attendi rould be detached for use	Completed by Physician	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of death	5 Other (specify)				World	Day Tou	
P.0	that the ned be deta	by P	Part II. Other significant conditions			he underlying cause (given in Part I	I. 23e.	Did tobac	co use contribute	to the cause of death?	
ds,	quires en sig ould b	ted	Congestive he	ar tail	OVE_			- 8	1 🗌 Yes	2. No 3	Probably 4 🗆 Unkno	wn
cor	has be	nple							— Was an autopsy performed	prior	autopsy findings availab to completion of cause o	
문	i: The la icate ha		05.14			-		1 🗍			Yes 2 □ No	
ita	sician certif recto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		_ 0	her:	th (Check only one)		- 🗆		
of V	Physer this eral d	은 :	27. Manner of Death	28a. Date of inju		e of 28c. Inju	ıry at	ursing Home 5		e b □ Otner (St njury occurred	эесіту)	
uc	ath. r: Afte	icat	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		y, Year) inju		rk? ☐Yes 2☐	No				
Division of Vital Records,	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ury - At home, farm c. (Specify)	, street, factory, office	,		ion (Street r Town, S		Rural Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has I een signed by the completed filled in by the funeral director, page 2 s rould be detach	Medical		ysician: To the best of	my knowledge, de	ath occured at the tin	ne, date and	place, and due to the	ne cause(s	s) and manner as	stated. he cause(s) and manner st	tated
	thin 2.	Me		rse Practioner: To the	best of my knowled	ge, death occurred at	the time, date	and place, and due	to the cau	use(s) and manner	as stated.	
	₽ .≱ ₽ 8		Achie And title of certifier	my Oz	111	10 00	5367	5	7	$\frac{1}{22/2}$	o ()	
	,		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	pe, Print)		·, 0 · -		=1/4=	MO 21921	,
10	DYIVA			Jontelcone	- MO	11160	Hgh Si	t Suite 21	t, C	_ I tion I	the cause(s) and manner stated. onth, Day, Year) OII MD 2192(
	Sta Régistr		31. Date filed (Month Der, Y2) 2	2011 Sener	ar's Signature	pare						

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 6:58PM Myrtle Virginia Malone 12 9011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lions Center for Rehab & Ext. Care Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/26/1943 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 💢 F 68 215-42-2563 Maryland **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Exemple count be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Cumberland 1X Yes 2 No Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 215 Emily Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 ☐Yes 2 📉 No Completed by If Yes, Give Ye ar or Dates: 1 ∐Yes 2 🕅 No Specify. Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hartley Marie Helen Haines 0scar Leslie ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
215 Fmilv Street. Cumberland, MD 21502 19a. Informant's Name/Relationship (Type. Print) 215 Emily Street, Cumberland, Thomas R. Malone / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Cumberland Crematory 07/14/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Selvice Licensee 404 Decatur Street, Cumberland, MD 00 23a. Part Total the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metasta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✓ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 1 ☐ Yes after death.

Director: After this certific
Jin by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46346 7/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue. Cumberland MD 21502 625 Kent

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

			State Registrar		Certi	ficate of D	Death		Reg. No.	
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
0.31	Medic		MARY JOAN MAGAHA					Month JUL		2011 6:15 A
	Examin	er	4a. Facility Name (if not institution, give street and n		4	4b. City, Town, or FREDEF		th		inty of Death DERICK
	Funeral		FREDERICK MEMORIAL H 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Bir		9 Rirthplace (State or Forei
	Funeral Director		5. Social Security Number 29-36-5465 220-24-545 Usual Residence of Decedent			Months Days	Hours Min		1933	Maryland
	and show	or	10a. State 10b. County	10c. City, To	wn or Locat	tion				10d. Inside City Limit
	Maryl 28a-f ptifiec	Director	Maryland Frederick	Free	derick	ζ				1 X Yes 2 □
	a or 2	Ö	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Country?
	h with	Funeral	1001 Young Place			21702				ted States
	r deat	y Fu	Armed	cedent Ever in U.S. Forces?	13, Wa	is Decedent of Hi es, specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - American Indian, Black, White, etc.
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	3 X Widowed 4 □ Divorced If Yes, 6 Year or	s 2 📉 No Give Dates.	1 [☐ Yes 2 🗓 No	Specify:		Spec	cify: White
15-(72 hou n "nati ledica	Completed	15. Decedent's Education (Specify only highest grade complete	ed) 16	(Give kin	nt's Usual Occupa d of work done o	ation Juring most of w	orking	16b. Kind o	f Business Industry
12	ithin ene. r thar	Con	Elementary/Seconday (0-12) College	(1-4 or 5+)		NOT use retired) uter Edi	tor		Pr-	int Media
	be filed w ental Hygi ked othe ic event,	Be	17. Father's Name (First, Middle, Last)		Oompo	acci_Lai		ame (First, Middle	•	
Maryland	d be fi denta rrked tic ev	욘	William Henry Swope				Marv	Lurene N	og1e	
any	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	1!	9b. Mailing	Address (Street a			_	n, State, Zip Code)
Σ	nd 2 sealth m 27		Julie Mackley / Daught	er 1	8 N.	Carroll	Street	Thurmor	nt, MD	21788
Baltimore,	re 1 ar tof H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from			ion (Name of tory or other plac		y [□] 279,	20c. Location	on - City or Town, State
ţ	t. Pag tmeni tant: jury o	3	4 Donation 5 Other (Specify)			Cremato		011		burg, Maryland
Ba	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even once.	(G 5	21. Signature of Funeral Service Licensee	MO1473	Ke	eneydand 6 E. Chu	Basfor rch Str	d PA Fun eet, Fre	eral Ho derick	ome, , MD 21701
			23a. Part I. Enter the disease, or complications the shock, or heart failure. List only one cause on	t caused the death. Do each line.	not enter t	the mode of dying	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
	Physician/	e y	Immediate Cause (Final disease or condition	COPI)					Onset and Death
-	Medical Examiner		resulting in death) Due	o (or as a consequence	e of):					
		ler	Sequentially list conditions, b. Due to	o (or as a consequence	e ofl:					
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or imjury	- (
	cate be executed physician and the burial-transit		that initiated events c. resulting in death) Last Due	o (or as a consequence	e of):					
90	te be nysicia ne bur	Medical	d							
98760	rtifical ling ph e as th	Mec	IF FEMALE:							
9 x	ath cert attendir for use	ian/	in the past 12 months?	outcome of pregnancy re Birth 2 Fetal dea			y			Date of delivery Month Day Year
Box	ires that the dea signed by the a Id be detached f	Physician	1 ☐ Yes 2 No 4 ☐ Pr 9 ☐ Unknown 9 ☐ Ur	egnant at time of death iknown	1 5 □ (Other (specify)				World Bay roa
P.0	that the		Part II. Other significant conditions contributing to	death but not resulting	g in the und	lerlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to the cause of death?
S,	uires l n sigr ald be	Completed by	High blood Pros	SYNE				. 1 💢	Yes 2 □ N	o 3 Probably 4 Unkno
orc	w require s been si 2 should l	plet						24a. Was		b. Were autopsy findings availab
3ec	sician: The law certificate has irector, page 2 a	mo;						auto	ormed? 2 No	death? 1 Yes 2 No
-B	sician: certifica		25. Was case referred to medical examiner?			26. Pla	ace of Death (C)		2,700	
5	Physic this ce al dire	2	1 Yes 2 No	¶ Inpatient 2 ☐ ER/0		3 DOA Othe	er: 4 🗌 Nursing	Home 5 ☐ Res	idence 6 🗆 0	Other (Specify)
Jo (ing P	ate:	Natural 5 Pending (M	te of injury 28b onth, Day, Year)	. Time of injury	28c. Injury work	?	28d. Describe	how injury occ	urred
Sior	ttend death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	as of laiva. At home	form street		Yes 2 No	00/ 1 11	(C)	h - Divid Broth Marshall
Division of Vital Records,	lor A after Direct		4 Homicide determined 206. Pla	ce of Injury - At home, ding, etc. (Specify)	iariii, street	i, ractory, office		City or To		mber or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier Certifying Physician; To the (Check 2 Medical Examiner; On the base)	best of my knowledge	e, death occ	cured at the time,	date and place	and due to the ca	ause(s) and ma	anner as stated.
	the Hu nin 24 the Fu	Mec	(Check 2 Medical Examiner: On the bounds only one) 3 Certifying Nurse Practione							
_	To the within 2 To the I		29b. Signature and title of certifier			29c. License	number		29d. Date sig	gned (Month, Day, Year)
	128m					P5	1643		7/29	111
	120		30. Name and address of person who completed ca	use of death (Item 23a) (Type, Prin	nt)	-		2	JII rednick 11
	Stat		31. Date filed (Month, Day, Year) 32.	Registrar's Sunature	1/1	ma	ع کام	w z an	by /	redmon 41
	Stat Registra	e ir	31. Date filed (Month, Day, Year) AUG 0 4 2011 Aug 132.	A. gare	18					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 18, Day 2011 Year James Penn 11:20 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17719 Livingston Rd. Accokeek Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 🛛 M 2 🗆 F Days Hours Min **Director** 214-42-5259 1944 Maryland 66 Sept. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified Accokeek 1 Yes 2 No Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17719 Livingston Road 20607 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced Year or Dates. J Mental Hygiene. marked other than "natura matic event, the Medical E White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James R. Penn Mary H. Atchison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Fellner 40415 Beach Dr., Mechanicsville, Md. 20659 Executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2011 cemetery, crematory or other place) July 20 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Metropolitan Funeral Service Alexandria, Virginia Signature of Fune al Service Lig Williams Funeral Home, M00668 4270 Hawthorne Rd., Indian Head, 20640 23a. Part 1. Ent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that better the cause or impury that the cause or instance or ins Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 | Yes 2 L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2. No ٩ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 \square Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No after death Director; / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ว4 hours a e **Funeral I** Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License number oba cco Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 201 1001a Medical Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Center: uMMC Baltimore Date of Birth (Month, Day, Year) 2 / 9 / 1 9 6 8 Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months 577-06-5944 Hours Director 43 DC Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10c. City, Town or Location

Middletown 10a. State 10b. County 10d. Inside City Limits Director MD Frederick 1 Yes 2X No 10f. Zip Code 21769 10e. Street and Numbe 10g. Citizen of What Country? Funeral 7330 Old Middletown Rd. USA Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ŏ þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify "natural", 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ John T. Perrin Joan Kirchhofer 19a. Informant's Name/Relationship (*Type, Print*)

James Goodman II (Husband) 7330 Old Street and Number or Rural Route Number, City or Town, State, Zip Code)
Middletown Rd., Middletown, MD21769 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 1X Burial 2 🗍 Cremation 3 Removal from State Lutheran cemetery 7/20/2011 Middletown, MD 4 Doyation 5 🗆 Other (Specify) ignary of Funeral Service License ²².Donald^{res}Bi-FacThompson Funeral Home Middletown, MD 21769 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ a consiguence Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Month Pregnant at time of death the Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 1 Unknown 24a. Was an 24b. Were autopsy findings available has autopsy perform prior to completion of cause of death? Yes 2 1 Yes Division of Vital funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of s after death, I Director: After t 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Hospital within 24 hours a To the Funeral I Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier Name and address of person State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # 2&3 Per PHY G927 5/30/2012 JH amend # 2&3 Per PHY G927 5/30/2012 JH State of Maryland / Department of Health and Mental Hygiene 2 1 1 24915 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Peath Month 13 Physician/ 2011 Euril William Perry, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Bowie Health Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 3, Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 1 **▼** M 2 □ F Hours 0k Tahoma 83 June 1928 448-22-7409 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No Prince George's Bowie Powie Marvland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? USA 12614 Millstream Drive 20715 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give 1 Year or Dates. Black, White, etc Š 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>aboratory Technician</u> Airforce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Louis Perry Lucille Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12614 Millstream Drive Bowie, MD 20715 Edith C. Bruton-Perry/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Washington Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /20/2011 Laurel, MD Signature of Edneral S 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arteriosderotic mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Directo for on a consequence of that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1-Natural 5 Pendina Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

death certificate be executed attending physician for use as the burial Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: hin 24 hours after deatl the Funeral Director.

Funeral

Director

28a-f show at

ems 23a or 28a-f sho r must be notified a

the Medical Examiner

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1 and 2 should by Health and Meitem 27 is mark

Department of Health Important: If item 27 any injury or other th

Physician/

Medical

the burial-transit

Examiner

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 19, 2011 Harold J. Rosen 5:00 AMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Ave Apt 317 Chevy Chase Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1**X** M 2 □ F Hours 96 02/02/1915 **Director** 117-12-0252 Yrs. NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MD Montgomery <u>Chevy Chase</u> Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or it 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nem z/ is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral 8100 Connecticut Ave Apt 317 20815 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4+ College (1-4 or 5+) Elementary/Seconday (0-12) Architectural Engineer Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jacob Rosen Mary Kanatopsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Mark Rosen – Son</u> Connecticut Avenue #LL2 4701 Washington, DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 07/22/2011 | Falls Church 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial hapels, Inc. 170 Rockville Pike Rockville, MD 20852 Rockville, MD 20852 23a. Part 1. Enter the dis ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiac arrest min. Medical Due to (or as a consequence of): Examiner Coronary artery disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated so or lingury) Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes years that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Colon Cancer 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 No death? 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year)

State Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 10810

Raman Tuli,

31. Date filed (Month, Day, Year)

609

Darnestown Rd., Ste 202 Gaithersburg, MD 20878

07/20/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 18 Margaret Recah Rifkind 2011 3:38p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5809 Nicholson Lane. #1201 Rockville Montgomery **Funeral** 8. Date of Birth (Month, Day, Y April 15 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Director Hours Min 218-82-3649 73 Great Britain Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5809 Nicholson Lane, 20852 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give "natural", 3 X Widowed 4 □ Divorced 1 ☐ Yes 2 🛣 No Specify Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meanone. Elementary/Seconday (0-12) Psychologist Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Raisman Nancy Applebaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Rifkind - Son 8705 Irvington Avenue, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Denation 5 Other (Specify) Judean Memorial Grdns: 07/20/2011 Olney, Maryland of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature M0075) 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer disease or condition 10 Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) n and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Day Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the 24a. Was an autopsv perform 2 X N Yes 25. Was case referred to medical 船 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify, ٦ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) e Funeral Director; After the leted filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45880 July 19, 2011 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Hwang, M.D. 1396 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year, State JUL 21 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 16.2011 VIRGINIA 12:35P M LORRATNE RUETTEN **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕌 Days Hours Director 060-22-3043 82 Yrs Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No MD Frederick Frederick 10e. Street and Number r items 23a or iner must be n ö 10f. Zip Code 10g, Citizen of What Country? Funeral 6922 Fish Hatchery Road 21702 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ö 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced 'natural", Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Postal Service Supervisor Be traumatic event, Page 1 and 2 should be filed v ment of Health and Mental Hyg ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bruno Lewandowski Agnes Kozlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Ruetten /son 6922 Fish Hatchery Rd., Frederick, MD 21702 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 107/22/2011 Frederick, MD Resthaven Mem. Gar. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hrain INIUI ansivic Medical Due to (or as a consequence of) Examiner arrest Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed armitation and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should k 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? page performed? Yes 2 N certificate 2 🗌 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Hospital Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
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filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral C

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DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Angel Hermosora Roque	State of Maryland / Department of Health and Mental Hygic
1- For State	Certificate of Death

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Angel Hermosura Roque 4a. Facility Name (if not institution, give street and number) 12001 Kemp Drive, S.W. 4b. City, Town, or Location of Death 12001 Kemp Drive, S.W. 4c. County of Death Allegany 4d. Allegany 4c. County of Death Frostburg 4d. Allegany 4d. Allegany 4d. Allegany 4d. Allegany 4d. County of Death Frostburg 4d. Allegany 4d. County of Death Allegany 4d. Allegany 4d. County of Death Frostburg 4d. Day Heyre Min			Registrar	Certificate	UI Dea	1011			Reg. No.		
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Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32/Registrar's Signature	6		Unes			O.C.M.I	Ε.		July 17, 20)11	
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State of Maryland / Department of Health and Mental Hygiene 2011 24920 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 9, 2011 7:39 Рм Edward Richard Radzwich Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Bowie Health Care Center Bowie If Under 1 Year **Funeral** Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F (Month, Day, Hours Min. Director 173-10-6969 96 Jan. 1915 Pennsylvania Usual Residence of Decedent 28a-f show 10b Counts rral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Marvland | Prince George's</u> Bowie 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 USA 12414 Stonehaven Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. "natural", or Completed by Yes Sive Baltimore, Maryland 21215-0036 1941-1961 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates. White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Military Officer U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Radzwich |Mary Lincalis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1327 Hunter Mill Road Vienna, Virginia Ferdensi/ Daughter VA 22182 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 10/1972011 cemetery crematory or other place)
Arlington
tional Cemetery 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) unk Arlington, VA Signature of neral Service Licens 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final AtherosderoTic Onset and Death Ph_sician/ Cardiovacca disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, reading to infine actions, it any, reading to infine action cause. Enter Underlying Cause (Disease or iinjury Duc to (or as a consequence oi): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo Pregnant at time of death Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? certificate 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 2 No Accident Investigation 24 hours after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			partment of Health and N	Mental Hygiene	
		1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No.	3. Time of Death
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Exan	nine	4a. Facility Name (if not institution, give street and number) 14608 Cutstone Way	4b. City, Town, or Location of Death Silver Spri		c. County of Death Montgomery
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth	9. Birthplace (State or Foreign
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ING 21215-UU36 Filed within 72 hours after death with the Maryland Ital Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 X No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Item 27 is marked other than "natural", o other traumatic event, the Medical Exam	4		ailing Address (Street and Number or Rura		
		20a. Method of Disposition 20b. Place of Dis	18 Cutstone Way, Si sposition (Name of		ocation - City or Town, State
O			rematory or other place)		lver Spring, MD
Baltimo permit. Page Department Important: I	ouce.	21. Signature of Funeral Service Licensee MO 1524	22. Name and Address of Facility Hi 11800 New Hampshire	nes-Rinald Ave Silv	i Funeral Home, Inc. ver Spring, MD 20904
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Pnysiciai Medic	_	Immediate Cause (Final disease or condition resulting in death) Cerebrovas cular Due to (or as a consequence of):	r Accident		Onset and Death 2 Weeks
Examine	er .				
g Ø≒	Fyamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury			
be executed sician and the burial-transit	E V	that initiated events c. The property of the	911111111 AM		
ate be ohysicie	100	d			
certifica nding p	M/d	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and expenditure of the funeral director, page 2 should be detached for use as the burial-final physician and expenditure that the funeral director, page 2 should be detached for use as the burial-final physician and the funeral director, page 2 should be detached for use as the burial-final physician and the funeral director.	Dhyeician/Mo	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
that the	hy Dh		e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
dS, quires en sign				1 🗆 Yes 2	No 3 □ Probably 4 □ Unknown
The law requires ate has been signage 2 should b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
an: The relificate tor, pag	Ro C		26. Place of Death (Check	1 Yes 2 X	
Physician: Physician: this certifical	ß	1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpa		me 5 X Residence	6 ☐ Other (Specify)
nding Pl ath. :: After the funeral	atec	27. Manner of Death 28b. Time 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury injury		28d. Describe how inju	ry occurred
INISION I or Attendir after death. Director: Af	Cortificate.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
To the Hospital o	odical				
the Ho thin 24 the Fu	Med	only one) 3 \(\subseteq\) Certifying Nurse Practioner: To the best of my knowledg	e, death occurred at the time, date and place	e, and due to the cause	(s) and manner as stated.
P 3 P 5	,	29b. Signature and title of certifier	29c. License number D09834		ate signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		
	tate	Barry Rosenbaum, M.D., 3721 Farrage 31. Date filed (Month, Day, Year)		ton, Maryl	and 20895
Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature	All and the second		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 24922 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M7/18/2011 10:24p M ROSEMARIE M. STEMMLER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac 10800 Barn wood Lane 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours (Month 2011/30 **Director** 282-30-4875 80 Germany Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 shculd Le filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is "ar-led other than "natural", or items 23a or 28a-f shown injury or other traus at event, the Medical Examiner must be notified at once. 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S 20854 10800 Barn wood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mathematician 4 National Bureau of Standard 8 B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Karl Scheerer Margaret Oesterlen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10800 Barn Wood Lane, Potomac, MD 20854 Roland Stemmler/husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Grematory Hanover, MD 7/20/2011 21. Signature neral Service Licenses 2. Name and Address of Facility Snowden Funera Home ring 7246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, r complication shock, or heart failure. List only one cause r complication hat caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Malignant neoplasm of the stomach Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	Todaking in dealin)	Due to (or as a consequence of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consequence of):								
dical Ex	that initiated events resulting in death) Last	C. Due to (or as a consequence of):								
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	topic pregnancy her (specify)		23d. Date of delivery Month Day Year					
ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No					
Be	25. Was case referred to medical examiner?		26. Place of Death (Chec	ck only one)						
၉	1 🗆 Yes 2 🗔 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing He	ome 5 X Residence	6 ☐ Other (Specify)					
Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b		28c. Injury at work? vi 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred					
	4 Homicide determined		actory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)					
Medical	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner as stated 2 Medical Examiner:									
	29b. Signature and title of certifier > Jocelyne	Kouertchou, m)	29c. License number D63748		ate signed <i>(Month, Day, Year)</i>					
1 1	30 Name and address of person who	completed cause of death (Item 23a) (Type Print)	•							

State

Registrar

31. Date filed (Month, Day, Year,

JUL 21 2011

Jocelyne Kouatchou, 201 East University Parkway, Baltimore, MD 21218

			1 - State Ce	ertificate of Death	Reg	. No.	
	Physicia Medic		Decedent's Name (First, Middle, Last) Elinor Marion Seger		2. Date of Death July 19	, ^{Day} 2011 ^{Year}	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number) St. Thomas More Nursing and Rehab Center	4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince Ge	eorge's
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \overline{X} F 7. Age (In yrs. last birthday, Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan . 16, 1	9. Birthpi 920 Mary	ace (State or Foreign ry) and
	Maryland 28a-f show stified at	rector	10a. State 10b. County 10c. City, Town or L 10c. Ci			10	Od. Inside City Limits
	with the I s 23a or 2 lust be no	Funeral Director	7101 Greenbelt Road	10f. Zip Code 20770		. Citizen of What Count United Stat	
0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ite event, the Medical Examiner must be notified at	ĝ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.
Maryland 21215-0036	within 72 hor giene. er than "nat , the Medica	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) EWITE	ing 16	own home	ustry
/land	Q = 3 0	To Be	17. Father's Name (First, Middle, Last) William Henry Schrom		e (First, Middle, Maio e Sophia	_{den Surname)} K atherine l	Erxmeyer
	and 2 should Health and Me em 27 is marl ither traumati		19a. Informant's Name/Relationship (Type, Print) Ernest W. Seger -husband 7101	ling Address (Street and Number or Rure Greenbelt Road Gr	al Route Number, Cit eenbelt,	ty or Town, State, Zip Ci Maryland 20	0770
Baltimore,	Page 1 arment of Herent of Herent in the item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition Cemetery, or Maryland V	position (Name of ematory or other place) Teterans Cemetery 7/26		c. Location - City or Tov heltenham,	
Ball	permit. Page Department of Important: If any injury or once.		Mercell V. 10 years	Bonald V. Borgward 4400 Powder Mill R	oad Belts	Home, PA ville, Mary	vland 20705
ا	hysician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac o			Approximate Interval Between Onset and Death
	pe <u>i</u> gu	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ininjury		-		
2	e be execury ysician and e burial-tra		that initiated events resulting in death) Last C. Due to (or as a consequence of):				
. Box 68/60	To the Nospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended earth. Within 24 hours attended earth. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buring transit.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ry Day Year
S, P.O.	ires that the signed by the detail		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
Vital Records,	The law requate has beer bage 2 shou	Completed	Parathy roids in		24a. Was an autopsy performe	prior to con	sy findings available appletion of cause of
Ö	ian: rtifica stor, I	Be (25. Was case referred to medical examiner?	26. Place of Death (Check		1101	
5	hysic his ce I dire	ျှ	1 ☐ Yes 2 🖪No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 🗆 Residence	e 6 Other (Specify)	
DIVISION OF	tending Peath. or: After the funera	Certificate:	27. Manner of Death 1	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	
DIVIS	oital or At urs after c ral Direct illed in by		4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)		City or Town, S		
	the Hosp hin 24 ho the Fune mpleted fi	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and p	lace, and due to the caususe(s) and manner as sta	se(s) and manner stated. ted.
	20 Z		29b. Signature and title of certifier Pun Clinel Vore hw	29c. License number 201855		Date signed (Month, D	
			30. Name and address of person who completed cause of death (Item 23a) (Type Paul ADE VORE MD 4 253 (Print) velnsbury Rd	Hyaths	will MD	20781
	Stat Registra	_	31. Date filed (Month, Day, Year) 2. Registrar's Signature	del.			

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sine Frankland Thomas Month July 22 Ž011 2:15 A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany 14012 Ellerslie Road Ellerslie 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 07/19/1919 Country)
Maryland 1 X M 2 🗆 F Yrs 219-03-9535 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Cumberland Allegany 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 12112 McMullen Highway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, irmed Forces?

XI Yes 2 \sum No 1943-Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S.P.S. 12 Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sine Grace Frankland Thomas Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 246 Autumn Chase Drive, Annapolis, MD Lois Milan / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MD Vet Cem @ Rocky Gap 07/26/2011 Flintstone, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F.A. of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Bleed with ostro1 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Physician/ Medical Examiner ital or Attending Physician: The law requires that the death certificate be executed urs are death.

ral Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

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ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I

should be filed with h and Mental Hygien 7 is marked other th

permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

the Maryland

with

72 hours after death

Baltimore, Maryland 21215-0036

_	To the Hospita	within 24 hours To the Funeral	completed filler	Medical
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in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of o				Month Day	Year
Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.		use contribute to the cau	
				24a. Was an autopsy performed?	24b. Were autopsy find prior to complet death?	tion of cause of
25. Was case referred to medical			26. Place of Death (Che	ck only one)		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 \(\sum \) Nursing F	Home 5 Residence	Dau 6 🛭 Other (Specify) R	ghter's
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Rout e)	e Number,
20a Cartifiar 1 X Cartifuing Phys	eician: To the best of my know	ledge death occured	at the time date and place a	and due to the cause(s)	and manner as stated	

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H0056080

29d. Date signed (Month, Day, Year)

July 22, 2011

21502

29c. License number

31. Date filed (Month, D L 25 2011

3

29b. Signature and title of certifier

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allison Evans-Wood, M.D., 17204 McMullen Highway, Cumberland, MD Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 07:3019M Shirey Robert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany WMHS-RMC Cumberland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country)MD 1 🗙 M 2 🗆 F Sep 14. 1933 220-28-9987 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location at 10d. Inside City Limits death with the Maryland Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 Sedgwick Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Korea Specify. white 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Kelly Springfield Tire Co. Shipping Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marguerite Mae Johnson Chancey Leon Shirey permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print)
Carol Shirey Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Buriar 2 □ Cremation 👂 □ Removal from State Frostburg Memorial Park 7/15/201 MD Frostbura 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linens 22. Name an Scarpelli Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for 4 Pregnant at time of death Month Day Year the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performed? Yes 2/N 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Fertifyi . Phy is ian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edic Examin : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 L only on erlify...g Nurse 29b. Signature and title 횬 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person when ompleted cause of death (Item 23a) (Type, Print) QUBROOK RD STE 670 (LIMPERLAND, MD 2150) MAN 31. Date filed (Month 15 201 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month VIRGINIA LEE SELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 □ M 2 ⋤ F Hours **Director** 215-26-6371 10/06/1927 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD **Allegany** Cumberland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21502 530 Favette Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gladys Ethel Hardy ပ Louis Herbert Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6673 Canada Goose Court, Frederick, MD 21703 Stephen P. Sell / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Peter & Paul Cem. 07/16/2011 Cumberland, MD ure of Funeral Service Licensee 22. Name and Address of Facility Upchurch Funeral Home, P.A 202 Greene Street, Cumberland, MD 21502 21. Signatu 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final Physician/ eD. disease or condition Medical resulting in death) Due to (or as a o insequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the i signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has be aral director, page 2 sl autopsy performed? Yes 22 No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No ၉ Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the ba Certifying Nurse Practioner: asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625

29c. License number

0033280

venue, Cumberland, MD

29d. Date signed (Month, Day, Year)

		Pleas	se Type or Pri									ble.	
	-	For State Registrar	State of Ma	arylan		artmei <i>rtificat</i>			Mental Hy		20		24928
Physicia		Decedent's Name (First, Middle, Alexander Leona		У					2. Date of D		f'5	žซี11	3. Time of Death 9:08 P M
Medic Examin		4a. Facility Name (if not institution, 2614 Vantage Co				4b. City	Town, or	Location of Deat	h	4	c. County of Anne	of Death Aru	ndel
Funeral Director		5. Social Security Number 183–18–2442	6. Sex 1 ½ M 2 □ F	e (In yrs. Ia	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min.	(Month, D	av, Year)	1921	Coun	place (State or Foreign try) nsylvania
yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne	Arundel	10c. City	y, Town or Lo	ocation	Anı	napolis		1812	- VIP	1	0d. Inside City Limits
h the Mar 3a or 28a- be notifi	Funeral Director	10e. Street and Number 2614 Vantage Co				10f. Zi	p Code	21401		10g. C	itizen of W	/hat Cour A •	1 ☐ Yes 2 ★No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ام	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E	No				ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	-	14. Race	- Americ	an Indian, etc. ite
thin 72 hours the. than "natur ne Medical E	Completed	15. Decedent	15. Decedent's Education (Specify only highest grade completed) 16a. Difference (1.4 or 5.1)			dent's Usu kind of wo OO NOT us Lef S	ork done o e retired)	during most of wo	rking		Kind of Bu		dustry
be filed wit ental Hygie ked other c event, tt	d)	17. Father's Name (First, Middle, Last) Alexander Joseph Slafkosky						me (First, Middle eth Labi		_		<u>-</u>	
d 2 should alth and M 27 is mar or traumat		19a. Informant's Name/Relationshi David Slafkosk			19b. Maili 214 I	ing Addres	s (Street a	and Number or Ri Avenue	ıral Route Numb Catonsv	er, City o	or Town, St , Mar	tate, Zip (ylan	d 21228
Page 1 and nent of Hez int: If item ity or othe		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		С	Place of Dispo emetery, cre Mary	matory or	other plac		Date 0/2011		Location -	-	_{own, State} Maryland
permit. F Departm Importa any inju once.		- / / /	XIII		2	2. Name a	nd Addre	ss of Facility J O					Home MD 21401
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or on shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	complications that caused aly one cause on each line a. Due to (or as a	Ca	h. Do not ent Vdiac	er the mod	de of dyin	g, such as cardia	or respiratory a	arrest,			Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
Attending Physician: The law requires that the death certificate be #r death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	aldeath 3	Ectopic Other (s		Sy			23d. Dat Mor	e of deliv	ery Day Year
v requires that the des been signed by the s should be detached to	ρ	2.5e. Did tobacco use contributing to death but not resulting in the diluterlying cause given in tare.											
he law requ te has beer age 2 shou	Completed								24a. Wa aut per 1 \subseteq Yes	opsy formed?	р	rior to co leath?	psy findings available impletion of cause of
ysician: The la is certificate ha director, page?		25. Was case referred to medical examiner?					26. Pi	ace of Death (Ch		> 2 (\$)	NO] I	100	2010
Physic this ce al dire	၉	1 Yes 2 No			ER/Outpatie		OA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)					2
ending P eath. or: After t he funera	Certificate:	Z Accident				of M	28c. Injur work 1 🔲		28d. Describe	28d. Describe how injury occurred			
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he Hosp in 24 hou he Funer pleted fil	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of each of the came of the ca	kamination	and/or inves	stigation, in	my opinio	on, death occurred	at the time, date	and place	ce, and due	e to the ca	use(s) and manner stated
To t with		29b. Signature and (it) of certifier	ishus			29	c. License	19838		29d. D	ate signed	(Month,	Day, Year)
Ask.		30. Name and address of person w	the completed cause of de LONICK, Management	eath (Item	23a) (Type, 2003	Print) Med	ical f	Parkwa	y, Ani	nap	olis,	Md	21401
Stat Registra	e	31. Date filed (Month, Day, Year)	2011 32. Registra	ar's Signat	ture	back	1						

11-05130	
Lindsey Stra	it

ease Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and M Certificate of Death	Il Copies Are Legible. 2011	24929
e (First, Middle,Last)	2. Date of Death	3. Time of Death

			1- For State Registrar	1	Certifi	cate of D	eath		,	R	leg. No.		
	Physici	ian/	Decedent's Name (First, Middle,Last)						2	. Date of Dea	ath		3. Time of Death
edica	l Exam	iner	Lindsay Strait J	r						Month July 9, 20	Day Ye	ear	2100 hrs
			4a. Facility Name (if not institution, give street	t and number)		4b. (City, Town, or	Location of	of Death		4c. County	of Death	1
			1027 Martha Court Apt. 1B			A	nnapolis				Anne A	rundel	
F	uneral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last b	irthday) li	f Under 1 Yea	ır İf Unde	er 24Hrs.	8. Date of Bi	rth(MM/DD/YYY		thplace (State or
D	irector	ŀ	248-42-2883 1XM :	2□F	79	Yrs.	Months Day	s Hours	Min.	Oct 7	7 1931	Foreig	ⁿ unt©arolina
			Usual Residence of Decedent			7 119.							
	ıny	1	10a. State 10b. County	10	c. City, Tow	n or Location							10d. Inside City Limits
-	E MOM	١.	Maryland Anne Aru	nde1	Anna	apolis	}						1 Yes 2 No
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,	r 28	Director				'							nu y r
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	ucata wan the Maryland nr items 23a nr 28a-f show any must be notified at once.	uneral		Vas Decedent Event Armed Forces?	er in U.S.	13. Was De	ecedent of His specify Cubar	spanic Orig n. Mexican.	gin? (Spec . Puerto Ri	cify Yes or No can. etc.)		e - Ameri te, etc.	ican Indian, Black,
-	nr it	Fur		Yes 2									
d	ral",	Ą	3 Widowed 4 Divorced If Yes, or Date	Give Yaar Vie	tnam	1 Ye:	s 2X No				Specify:		.ack
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5-0036	Medi	Ę	11th	0		Supe	rvisc						ademy
2	the Spanish		17. Father's Name (First, Middle, Last)						•		Maiden Surnam	e)	
2121	and Mental Hygiene. 7 is marked other than natic event, the Medical	Be	Lindsay Strait S							Grif			
7	is my	ဥ	19a. Informant's Name/Relationship (Type, P	rint)							mber, City or To		
A C	Ith ar		Phyllis Strait(W:	ife)									21403
စ် ဒီ	eges ; and z stoud or other within to hours arter to of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the <u>Medical Examiner</u>		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re			of Disposition atory or other p		metery,		Date	20c. Location	- City or	Town, State
0	of it of			noval from State		yland	•	an I	7-18	3-11	Crown	nsvi	11e, Md.
Baltimore,	pount. 1 egos 1 and 2 shows or they within 72 hours after usun with the Maryyand Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a nr 28a-f sho injury nr other traumatic event, the <u>Medical Examiner must be notified at ones</u>		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		TIGE _						tuary,		
Ba	Departi Import injury		7 400								polis,		
Phy	sician		23a. Part I. Enter the disease, or complication	s that caused the	death. Do r								Approximate Interval
	lection).		failure. List only one cause on each line										Between Onset and Death
Ēxa	aminer			osclerotic Ca (or as a conseque		ular Diseas	se						Boder
			b	(or as a conseque	srice or).								
		ē	Sequentially list conditions, if any, leading to immediate Due to	(or as a conseque	ence of):								
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-	, . <u>.</u> ;	Examine	events resulting in death) Last Due to	(or as a conseque	ence of):		-						
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760,	phys he bi	/¥e		If yes, outcome o	f pregnancy	1					23d. Date o	f delivery	,
	ding e as 1		23b. Was decedent pregnant in the past 12 months?	Live birth		2 Fetal de	eath 3	Ectopic	pregnanc	у	Month	0	Day Year
Box	e attending for use as t	sic	1 Yes 2 No 9 Unknown 9	Pregnant at time Unknown	ordean	5 Other	(Specify)						
a	by the	Physician	Part II. Other significant conditions contril	The second second	t not reculti	na in the under	rlying cause o	iven in Par	et I	23e Did to	phacco use cont	ribute to	the cause of death?
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v	n sig	P	Diabetes mellitus, prostate car	Cinoma					_				
D 3	s been should	Bet								24a. Was autop	sy	prior to c	topsy findings available completion of cause of
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of Vital Records,	this certificate I director, page	Be C	examiner? 1 ✓ Yes 2 No	1 Inpatient	2 ER/C	Outpatient 3		Other ₄			Residence 6	✓ Other	: Scene
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Z i	E F	Certification:	1 Natural 5 Pending	(Month, Day, Year)			1□ \	'es 2	No				
Sic	r dea recto	<u>s</u>	2 Accident Investigation	e. Place of Injury	- At home.	farm, street fa	ctory office b	uilding etc	28	f Location (5	Street and Numb	per or Ru	ral Route Number, City
Division	ours after death cral Director: filled in by the	ŧ	Suicide Could not be	Specify)				and and		or Town, S			,,
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He H	within 24 h To the Fun completely	Sa	(Check only 1 Certifying Physician: To one) 2 Medical Examiner: On the										
Tot	within 24 hours a To the Funeral I completely filled	Medical	2	anner stated.			29c. License			,			
		-	255. Signature and the or certifier	11 2	~						29d. Date sign		nn, Day, rear)
	اد		Men Brasin	11/11/2	7		O.C.I	VI.⊏.			July 10, 20	ווע	
	6		30. Name and address of person who complete										-
	W		Melissa Brassell, MD Assista	nt Medical Ex	aminer	900 W. Ba	altimore S	treet, Ba	altimore,	MD 2122	23		
	91	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24930 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $20^{\text{Year}}\!\!1$ Physician $\mathsf{J}^{\mathtt{MODUN}}_{\mathbf{L}}\mathtt{Y}$ SWEENEY 2ඁඁඁඁ ELLA LOUISE 9:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 10209 FORD TERRACE WHITE PLAINS CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F 212-54-5555 63 MAR.12,1948 Director OHIO Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location show sa or 28a-f show Director 1 ☐ Yes 2 No MD CHARLES WHITE PLAINS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10209 FORD TERRACE ms 23a 20695 U.S. Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐Yes 2€500 event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3X Widowed 4 □ Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) LEASING CONSULTANT APARTMENT BUILDING 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H
Ith somether ith and Be MILDRED L. BAKER GEORGE ALFRED DEAN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a DENISE RICHARDS / DAUGHTER 103 SPENCERS AVE., SOUTH MILLS, NC 27976 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) JUL Pate jo J permit. Pages Department of Important: If it any Injury or c once. 1 ☐ Burial 2XX remation 3 ☐ Removal from State 30,2011 METRO.CREMATORY ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licer M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Ou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final 3 mos, **Physician** ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed Exami signed by the attending physician and ibe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mont 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ s been signated by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ospital or Atten.
44 hours after death.
al Director: A 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier gr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waldorf, MD omas State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $JuLy^{\text{Month}}$ Physician/ ^D2011 Mary G. Thompson 16. 4:33 p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 33 Highland Place Indian Head Charles Social Security Number 8. Date of Birth (Month, Day, Year) May 6, 1924 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours 219-12-3669 **Director** 87 Maryland Usual Residence of Decedent ifiled within 72 hours with that Hygiene.
ed other than "natural", or items 23a or 28a-f show a of the than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles Indian Head 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 Highland Place U.S.A. 20640 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Store 8 permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph S. Burch Jennie Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold M. Scott Nephew 48 Poplar Lane, Indian Head, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place July 20a. Method of Disposition 21, 1 X Burial 2 Cremation 3 Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Signature of Funeral Service Licer Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md 23a. Part 1. Ente issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart filture. List only one cause on each line. Interval Between Onset and Death Immediate Ca se inal disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Day Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home hours after death. Ineral Director: After this 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Vatural
2 Accident
3 Suicid 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital 24 hours Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date-signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07:20 PM M Jean F. Truly July 2/2, 201 Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Allegany** Examiner WMHS Frostburg Nursing & Rehab Center Frostburg 5. Social Security Number If Under 24 Hrs. 6. Sex If Under 1 Year 8 Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Min 1 M 2 X F 235-30-0142 86 November 22, 1924 Warvland Director Usual Residence of Decedent 28a-f shov 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Allegany Frostburg 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 127 Washington Street 10f. Zip Code Funeral items 23a U.S.A. 21532-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any lijury or other traumatic event, the Medical Exan any lijury or other traumatic event, the Medical Exan Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) OCollege (1-4 or 5+) Elementary/Seconday (0-12) Cashier Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rex Frankland Catherine Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21532-Norma Davis Maryland daughter 404 Grandview Drive Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Cumberland Crematory 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland July 13, 2011 4 Donation 5 Other (Specify) Signature of 5 meral Service Licensee Name and Address of Facility
 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 lestates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CHRONIC OBSTRUCTIVE LUNG Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical anding pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗀 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 Tes 2 🔲 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun

State

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Harjit Sidhu

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2011

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32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Bishop Walsh Drive, Cumberland MD 21502

29c. License number 026901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24933 State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day ernardo uball PM 1030 Medical 4a. Facility Name (if not institution, give street and number)
CENESTO SCULYNE PAUL
TV14 (ILL) WWY ROAG 4b. City, Town, or Location of Death Examiner 4c. County of Death Cellers July Severna pasu Anne Arun inst If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Aug 8 Min. 1 **X** M 2 □ F Hours Maryland [°]1[°]927 220-16-4651 Director 83 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f 1 ☐ Yes 2 🛣 No Severna Park Maryland Anne Arundel 10e. Street and Numbe items 23a or ner must be n ö 10f. Zip Code 10g. Citizen of What Country? Funeral USA 862 Manhattan Beach Rd. 21146 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 XYes 2 No
8 of Year Give 11-1946 Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black "natural" Completed 3X Widowed 4 ☐ Divorced al Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) S Naval Academy Elementary/Seconday (0-12) College (1-4 or 5+) Printer Print Shop O ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Parker Flaviano Tubaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Quiet Waters Place Annapolis, Md. 21401 Argo Duenas (Daughter) 161 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 7-22-11 Crownsville, Md. Maryland Veteran 4 Donation 5 Other (Specify) Miname a Received Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lanny Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition 10 year Medical resulting in death) Due to (or as a consequence of): **Examiner** Service tiplik list over littera if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical certificate be attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death in the past 12 months?
1 Yes 2 No jo Month Day Year be detached the P.O. Hospital or Attending Physician: The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performe 2 🗆 No Yes 2 Ch Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this ed in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) lunu mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive # 1A. Annapolis, Mp 21401 200 11 dewater Calenes 31. Date filed (Month, Day, Year) State Registrar

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Ed	ducation (Speci	fy only highest grad	de completed) -4 or 5+)		- X	upation (Given)	ve kind of v		So	Kind of Busines	s/Industry curity
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Baltimore, sermit. Pages I as Department of Hes Important: If ite nijury or other tr		1 Burial 2		3 Removal fro	om State	crematory or oth	er place)		7/				
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noi	ttending death. tor: Afte the fun	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury		? Yes 2 🗆 No				
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate F completed filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, tarm, stre	et, factory, office		28f. Location (St City or Town		nber or Rural	Route Number,
	e Hospi n 24 hou e Funer	Medical	(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination actioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and	due to the car	use(s) and manner stated.
	To th withii To th	_	29b. Signature and title of certifier	HIMBOD .	knowledge, death occurred at the time, date and place, and due to				29d. Date sign	.010	
7	Bral		30. Name and address of person who comp	leted cause of death (Item	23a) (Type, P	rint)	1421	11 1 -	04/6	1/20	270
/l.	B54	e	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	1555)	urrost	2 M) (Tinto	11,111	() 2	0100
	Registra	_	JUL 2 1 201	Alexander	ps. 19	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 24936 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2011 20:10 PM <u>ALICE VIRGINIA WILLIAMS</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ELKTON CARE AND REHAB ELKTON CECIL 8. Date of Birth
(Month, Day, Year)
JAN 31.1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Min 1 □ M 2 💢 F Months Days Hours **Director** 219-28-7585 89 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified XX Yes 2 No MARYLAND CECII NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral BERTRUM COURT APARTMENT 1 21901 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: BLACK "natural", Completed 3 🔀 Widowed 4 🗆 Divorced Year or Dates of and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natur rother traumatic event, the Medical Ir 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) UNITED STATES Elementary/Seconday (0-12) College (1-4 or 5+) DIETICIAN GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRY BRISCOE SALLY YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE SALLY HALL/GRANDDAUGHTER 1 BERTRUM COURT, APT. 1, NORTH EAST, MARYLAND 21901 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State ST CEMETERY CONTROL OF CEMETERY JULY₁23, 5 Other (Society) ELK NECK, MARYLAND 4 Donation 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. Signatu 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 wart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to lo **Examiner** 100 Sequentially list conditions, Examine as a considuence of cause. Enter Underlying Cause (Disease or iiniury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð lautretron 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. 29d. Date signed (Month, Day, Year) Name and address of person on who completed cause of death (Item 23a) (Type, Print) main ader 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month July DONALD HOOPER WILES 6:58 A M 16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🔀 M 2 🗆 F 76 **Director** 214-34-1007 MD Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Frederick Myersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9082 Dawn Ct. 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 SpecWhite 1 Yes 2 No Specify: 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sexton church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William S. Wiles Annie Hooper 19a. Informant's Name/Relationship (Type, Print)
Patricia Wiles (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $9082\ Dawn\ Ct.,\ Myersville,\ MD\ 21773$ permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Reformed Cemetery 7/21/2011 20c. Location - City or Town, State 1 ☐XBurjal 2 ☐ Cremation 2 ☐ Removal from State 4 ☐ Donation 5 ☐, Other (3 pecify) Middletown, are of Fin eral Servic ²²DonalAdreBofFaoThompson Funeral Home POB 18, Middletown, MD 21769 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 14 CEST CARDIOPULMONARY Ph sician/ disease or condition 1 140 1 Medical resulting in death) Due to (or as a consequence of) Examiner DISGASE فعردن CRONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or) -tran Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗌 No 1 Tes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tes 2 1 No 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Hospital or Attending P 24 hours after death.
 Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and

31. Date filed (Month,

e of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MIDDLETOWN,

7-16-2011

29c. License number D20488

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20

			1 - For State Registrar	State of Ma	arylan		artment of I <i>tificate of I</i>		Mental Hy	giene Reg. Na	21111	24938
I	Physicia Medi		1. Decedent's Name (First, Middle, La Doris L. Whitehead	st)			-		2. Date of De Month	ath	B, 2011 Year	3. Time of Death 11:50 AM M
	Examir		4a. Facility Name (if not institution, give Frostburg Village Nursi				4b. City, Town, o	r Location of Dea	th		. County of Dea	th
	Funeral Director		5. Social Security Number 6. S 215-26-9521	ex	81 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min				thplace (State or Foreign
	iryland a-f show fied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Allegar	nv.		, Town or Loc	ation					10d. Inside City Limits
	vith the Ma 23a or 28a ist be notif	eral Dire		Whitehead La			10f. Zip Code 21543 -			10g. Ci	tizen of What Co	1 ☐ Yes 2 🗷 No ountry?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		- 1	/as Decedent of H Yes, specify Cuba ☐ Yes 2 KNo		Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
21215-0036	vithin 72 ho liene. er ti an "na the Medica	Comple	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		+)	(Give k	ent's Usual Occup ind of work done o O NOT use retired) stress	ation during most of wo	orking		ind of Business	Industry
Maryland 2	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) William Atkinson					18. Mother's Na Viola M 6	me (First, Middle,	Maiden	Surname)	
	nd 2 shoul ealth and I m 27 is ma her trauma		19a. Informant's Name/Relationship (7) Lynn Kyle	/pe, Print) Daughter			g Address (Street a ugar Maple F		ural Route Numbe arton	er, City or	Town, State, Zi Maryland	o Code) 21521-
Baltimore,	. Page 1 al tment of H tant: If itel jury or oth	E . (r)	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	Ce	emetery, crem	sition (Name of atory or other place nd Crematory	ce)	Date July 18, 2011		ocation - City or mberland	Town, State Maryland
Bal	Depar Impor any in		21. Signature of Funeral Service Licens	ee ers		22.	Name and Address Durst Funer	ss of Facility Mal Home, 5	7 Frost Ave.	, Fros	tburg, MD	21532
	Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as a c. Due to (or as a Due to (or a) Due to (or	Consequence consequence	ence of):	The mode of dyin	MOSTE O	c or respiratory ar			Approximate Interval Between Onset and Death
. Box 68760	e death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	of pregnan	ncy death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year
ords, P.O.		Completed by Ph	Part II. Other significant conditions or	ontributing to death bu	t not resu	llting in the un	derlying cause giv	en in Part I.	1 🗆 24a. Was	Yes 2 an	□ No 3 □ P	the cause of death? robably 4 Unknown topsy findings available
al Rec	an: The la tificate ha or, page 2	ادہ	25. Was case referred to medical				26 DI	ace of Death (Che	1 Tes	osy rmed? 2 No	death?	completion of cause of
Division of Vital Records,	nding Physicie ath. rr: After this cer ne funeral direct	Certificate: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatier 28a. Date of injury (Month, Day,	/ 2	ER/Outpatient 28b. Time of injury	3 DOA Othe	4 Nursing F	Home 5 Residence			ify)
Divisi	ital or Atte Ins after de ral Directo led in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		ne, farm, stree	et, factory, office		28f. Location (S City or Tow			ral Route Number,
	the Hosp thin 24 hou the Fune mpleted fi	Medical	(Check 2 L' Medical Exami	ician: To the best of mer: On the basis of exa e Practioner: To the b	amination	and/or investic	gation, in my opinio eath occurred at the	n, death occurred time, date and pl	at the time, date a ace, and due to the	nd place e cause(s	, and due to the o) and manner as	cause(s) and manner stated. stated.
9	7		>	1 Freller	-1L ()	20.10	29c. License	6907			te signed (Month	
	1125		30. Name and address of person who c	925 Bis	hop '	Walsh 1	Road, Cur	mberland	, MD 215	502		
	Stat Registra	٠,	31. Date filed (Month, Day, Year) JUL 18 201	32/Registrar	s Signatu	bar	Kal					

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

			For State	State of M	aryland		rtment of H		ind M	•	•		01	000
			Registrar 1. Decedent's Name (First, Middle	Loot)		Cer	tificate of D	<i>Jeatn</i>			Reg. No	UIL	24	939
	Physicia Medic		Ruby	Maxine		Watso	n	•		2. Date of Dea Month July	ath 18, Day	20 11 ^{Year}	3. Time (
4	Examir		4a. Facility Name (if not institution	give street and number)			4b. City, Town, or	Location of	Death			County of Death	า	
			Allegany Healt				Cumber					All	egany	
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	e (In yrs. las 73	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day 02/16/	h (Year)	9. Birt	hplace <i>(State</i> <i>Intry)</i> St Vir	or Foreign
			218-34-4496 Usual Residence of Decedent		13					02/10/	1930	wes	st Vir	ginia
	and shov	힏	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside 0	Dity Limits
	Mary 28a-f otifie	Funeral Director	MD A1	legany		Cur	nberland						1 🛚 Ye	es 2 🗌 No
	a or		10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?	
	h with	ner	135 N. Mechan	ic Street, A	pt 60	1	215	02				USA		
	deat riten	II.	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	las Decedent of His Yes, specify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto F	cify Yes or No- Rican, etc.)	14	4. Race - Amer Black, White		
21215-0036	after al", o	d by	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No		☐ Yes 2 🗓 No				S	necify:		
Ö	hours natura ical E	lete	15. Decede	nt's Education		16a. Deced	ent's Usual Occupa	ation			16h King	d of Business I	White	
215	in 72 e. nan "r Med	Completed		st grade completed) College (1-4 or 5	<u></u>	(Give k	ind of work done d NOT use retired)		of workir	ng	TOD. TUITO	7 OI DUSINOSS I	ridustry	
7	withi /gien rer th		Elementary/Seconday (0-12)		.,	Hor	nemaker					Home		
pu	e filed Ital Hy ed ott	To Be	17. Father's Name (First, Middle, L	,	D	- 1-1				(First, Middle,		,	7	
Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "hatural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at		Carl 19a. Informant's Name/Relationsl	Cecil	т	ckburı		Cle			eona		auley	
, Ma	nd 2 sho salth an n 27 is er trau		Michael W. Tw				g Address (Street a Amherst							
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cer	netery, crem	ition <i>(Name of</i> atory or other place and Cremat		_	ate		ation - City or		
altir	permit. P Departme Importar any injur		21. Signature of Funeral Service L		1 Cum		Name and Addres	- 1					•	P.A.
8	9 E E O		- William of	loans			04 Decatu					, MD 2	21502	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that caused nly one cause on each line	the death.	Do not ente	the mode of dying	g, such as ca	ardiac or	r respiratory arr	est,		Approxima Interval Be Onset and	tween
4	Inysician/ Medical		disease or condition resulting in death)	a	w	a C	nccin	one	70	Meti	30+1	78is	Orișet and	Death
	Examiner		Marie Company of the	Due to ras	conseque	nop ot):	Anter	×1 -	75	SEAST				
	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):	11/ 11	7		SUR			_	
	death certificate be executed re attending physician and ed for use as the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	OF	nce of):	MEILI	tus						
0	be ex sician burial	calE	rooding in deathy 245.		2 0011004001									
760	icate phys s the	ledi		d										
687	ath certifica attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc						23	3d. Date of deli	verv	
Вох	death e atte	sicia	in the past 12 morths? 1 ☐ Yes 2 ☑ No	1 Live Birth 4 Pregnant a			Ectopic pregnancy Other (specify)	y 				Month	Day	Year
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s, P.O.	The law requires that the dea ate has been signed by the a page 2 should be detached f	d by	Part II. Other significant condition	ns contributing to death b	ut not result	ting in the ur	derlying cause give	en in Part I.				contribute to	_	
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E H	sician: The certificate rector, pag	Be C	25. Was case referred to predical				26 Pla	ice of Death	(Chack		2 No	1 🗆 Yes	2 🗆 No	
Vita	S S I	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 El	R/Outpatient	Other	r: _/		ne 5 🗆 Resid	onoo 6 [Other (Speci	64	
of	ng Phys ter this neral dir		27. Mann of Death 1 Natural 5 Pendin	28a. Date of injur	γ 2	8b. Time of injury	28c. Injury work?	at		8d. Describe h				
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Division of Vital Records,	or Attending after death. Director: After in by the fune	Certificate:	4 Homicide determ		ry - At hom . (Specify)	e, farm, stre	et, factory, office		2	8f. Location (S City or Tow		lumber or Rum	al Route Num	ber,
Ω	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of	my knowled	lge, death o	ccured at the time,	date and pl	ace, and	I due to the cau	ise(s) and i	manner as sta	ted.	
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral in the funeral by the	Me	only one) 3 La Certifying 29b. Signature and title of certifier	kaminer: On the basis of ex Nurse Practioner: To the	pest of my k	nowledge, de	eath occurred at the	time, date a	ind place	, and due to the	cause(s) a	nd due to the cand manner as s signed (Month,	stated.	arrier stated.
	2		Macon	- CRU	P			370	60	4	Jane 9	7/18/		
	∞		20. Name and address of person v	tho completed cause of de	eath (Item 2	3a) (Type, Pr		7	h		1	ATA	OK	2
	//∕∕∕√ Stat	е	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	· hor	ST (un	-IE	y 'UHU	<u> </u>	MU)	XU	91
	Registra	ir	JUL 20 20	III Skrin	Fi.	1 and								

			1 - State Registrar			Ce	rtificate of	Death		Reg. No.	2011	24940
	Physici /Medic		1. Decedent's Name (First, Midd Joseph	le, Last) Lee		Walli	zer, Jr.		2. Date of D	Day		3. Time of Death
-	Examir		4a. Facility Name (If not institution	n, give street and n	ımber)		4b. City, Town, o	r Location of Deatl	h 1		County of Death	
and the			Lions Center fo	r Rehab 8	Ext C	are	Cu	umberland	l		All	.egany
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		place (State or Foreign
	Director		218-30-2404	1 □ X M 2 □ F	78	Yrs.	Months Days	Hours Min.	8. Date of B (Month, L 03/26)	1933	Mar	intry) 'yland
	ъ		Usual Residence of Decedent									
	ylan		10a. State 10b. County		10c. 0	City, Town or Lo	ocation					10d. Inside City Limits
	Mar F st	ģ	MD All	.egany			Flintst	cone				1 ☐ Yes 2 🌠 No
	the 283	rec	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a fivelest Examination to other traumatic event, it as fivelest Examination once.	Funeral Director	12201 James	Stewart R	oad, N	E	2	21530			USA	
	ns 2	era	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H	dispanic Origin? (S	Specify Yes or N	io-	14. Race - Amer	ican Indian,
	iter d	Ē	1 □ Never Married 2 □ Mai	Armed F			If Yes, specify Cub	an, Mexican, Puerl	to Rican, etc.)		Black, White,	
21215-0036	rs af	þ.	3 ☐ Widowed 4 💢 Divorced	If Yes G	ive		1 □Yes 2 🗓 No	Specify:			Specify:	White
ö	hou tura	Completed by		nt's Education		16a Dece	edent's Usual Occup	nation		16b. Ki	ind of Business/Ir	
15	n 72 1 "na	Set	(Specify only highe	est grade completed		(Give	kind of work done DO NOT use retire	during most of wor	rking			•
12	withi ene. thar	Ĕ	Elementary/Secondary (0-12)	College	(1-4or 5+)		Carpente	,		Co	onstruct	ion
7	Hygi Hygi ther int, I	ŭ	17. Father's Name (First, Middle,	l ast)			F	18, Mother's Nar	ne (First, Middi			
an	d be	Be	Joseph	Lee		Wall.	izer, Sr.	Edna		Marie		emer
Maryland	d Me d Me nark natic	은	40- Information No. 10-1-10-1	-bi- (T D-i-1)		405 14-11	ng Address (Street	and Mirror and an Or			Taura Ctota 7	in Codo)
Ma	12 st than 7 is r traur		19a. Informant's Name/Relations Donald Wallize		on.		ng Address <i>(Street</i> 06 Black					
o,	l and lealt			r / broth					Date PII		ocation - City or T	
Baltimore,	ges 1 It of H If ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Removal from	State	cemetery, cre	osition (Name of matory or other plac	ce)	Date	200. LC	Cattori - City of 1	Owii, State
Ē	men mant:		4 □ Donation 5 □ Other (5		Cu	umberla	nd Cremat	ory 07/	26/2011	Cı	umberlan	
all	pparl pparl pporl ny in		21. Signature of Funeral Service	Licensee	/	I						Home, P.A.
Ш_	90 = P 9		MILLIA	Udansk		4	04 Decatu	r Street	, Cumbe	rland	d, MD 2	1502
			23a. Part 1. Intel the disease shock, or heart failure. Lis	r complications that	caused the de	ath. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final		450 TOS	Me	TRIANTIN	E DILLA	and ou	Du	THE	Onset and Death
	/Medical		disease or condition resulting in death)		(or as a conse		TRUCTIVI	PULI	MAHIET	2/10	EMOR	Y OHK!
	Examiner				(,						
		ē	Sequentially list conditions if any, leading to immediate	b. Due to	(or as a conse	equence of):						
	uted d ansit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S								
	exec	Xa	resulting in death) Last	cDue to	(or as a conse	equence of):						
68760,	ertificate be executed ding physician and se as the burial-transit											
387	ficate phy s the	Medical		d								
	leath certific attending p for use as t		IF FEMALE:	23c. If ves. or	utcome of preg	nancv					23d. Date of deli	VARV
Box	atter for u	Siar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 🗖 Fe	tal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			Month	Day Year
O.	The law requires that the death or ate has been signed by the attent bage 2 should be detached for us	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk		i dealii 51	Other (specify) _					
σ.	that t ed by detac		Part il. Other significant conditi	ons contributing to	death but not re	esulting in the u	ınderlying cause giv	ven in Part I.	23e. Dio	tobacco u	use contribute to	the cause of death?
ď,	signe signe	b							1.5	Yes 2	□ No 3 🕍 🕶 ro	obably 4 🗆 Unknown
O.C.	w requires been sign should be	ted							1			
ec	law las b	ag .							24a. Wa	as an lopsy	prior to c	topsy findings available ompletion of cause of
Vital Records,		Completed							pei 1 □ Yes	formed?	death? 1 ☐ Yes	2 /20 0
Ħ	Physician: The rthis certificate ral director, page	Be (25. Was case referred to medica	ıl				26. Place of De				
+	Physic this ce al direc	2	examiner? 1 ☐ Yes 2 ☑No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 □ DOA Oth	ner: 4 Nursing H	Home 5 ☐ Re	sidence	6 ☐Other (Spec	cify)
Division of	g Pt ter th	<u> </u>	27. Manner of Death	28a. Date	e of Injury nth, Day, Year)	28b. Time of Injury	of 28c. Inju Wor		28d. Describ			
jo	Attending r death. ector: After by the funer	atio	1 Natural 5 ☐ Pendii 2 ☐ Accident invest	igation	illii, Day, Teai)	li lilijar y		Yes 2 □ No				
15	Attend r death sctor; by the f	Ę	3 ☐ Suicide 6 ☐ Could	ninged 28e. Plac	e of Injury - At	home, farm, st	reet, factory, office		28f. Location	(Street ar	nd Number or Ru	ral Route Number,
Ö	II or Attending P after death. I Director: After d in by the funera	Certification:	4 ☐ Homicide determ	build	ding, etc. (Spe	спу)			City or I	own, State	?)	
	spita nours nera nera		29a. Certifier 1 Certifyi	ng Physician: To th	e best of my k	nowledge, dea	th occurred at the t	ime, date and plac	e, and due to the	ne cause(s	s) and manner as	stated.
	e Ho e Fu letel	Medical	(Check only 2☐ Medical one)	Examiner: On the and ma	basis of exami nner stated.	nation and/or i	nvestigation, in my	opinion, death occ	urred at the tim	e, date and	d place, and due	to the cause(s)
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	Me	29b. Signature and title of certific		-		29c. Licens	se number		29d. Da	ite signed (Month	n, Day, Year)
	./		1	2	7/		DO	05400	4	7	25-	2011
7	1/IVA		30 Name and address of name	m / Le	appropriate /	om 220\/T			-		45	2011
	SIRI		30. Name and address of person	who completed cat	ise or death (It			1	. 1 -	1/21	m	21502
	111 1	to	31. Date filed (Month Day Year	33	Registrar's Sign		boroiti	uiduma	y, L	LVOU	41111	9120g
	Sta Registr		31. Date filed (Month, Day, Year, JUL 25	2011	arad .	A Son	Med	_				
			005 %	- Ken	ann 1	- A.						

		For State	State of M	aryland		artment of tificate of		and M		2.0	11	24941
		Registrar 1. Decedent's Name (First, Middle.	Last)		Cel	uncate of	Death		2. Date of Dea	Reg. N.C. U		3. Time of Death
Physicia		William	Cohlen		Wagne	r			Month	22	20 11	064/A M
Medic Examine	er	4a. Facility Name (if not institution, Western MD Regio		Cent		4b. City, Town	n, or Location of			4c. Coun	ty of Death	
Funeral Director					st birthday) Yrs.	If Under 1 Ye Months Day			8. Date of Birt) 920		place (State or Foreign oftra) y Land
d tow	- 1	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					·	10d. Inside City Limits
farylan 3a-f sh tified a	Director		egany	100. 01.)	01dtc							1 Yes 2 X No
h the M ka or 28 be not	흡	10e. Street and Number	11 1 7		_	10f. Zip Cod				10g. Citizen o	f What Cou SA	ntry?
ath wit	Funeral	15915 UIC E	raddock Tra				21555 of Hispanic Orig uban, Mexican,	in? (Spe	cify Yes or No-		ace - Ameri	can Indian.
after de al", or it	اڇ	1 ☐ Never Married 2 🗶 Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		Yes, specify Co		, Puèrto I	Rican, etc.)		ack, White,	
2 hours "natur	plete		t's Education st grade completed)			lent's Usual Occ	cupation ne during most	of worki	na	16b. Kind of	Business Ir	ndustry
within 7% giene. ier than t, the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)		NOT use retire Painte:	red)			Ai	rcraf	t
d be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, L William	ast) Clevelan	d	Wagne	er	18. Mothe		e (First, Middle, Sar		me) Beam	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a Informant's Name/Relationsh Jessaline D. W							I Route Number			
ige 1 and nt of Hea nt of Hea r or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Removal from State	20b. Pl	emetery, cren	sition (Name of natory or other p	place) atory 0		Date / 2011	20c. Location	n - City or 1 erlan	
ermit. Pa lepartme nportani ny injury		4 Donation 5 Other (S		Cun	22	. Name and Ade	dress of Facility	, Ada		ly Fun	eral	Home, P.A. 1502
00 = 80	\dashv	23a. Part 1. Enter the disease, or									MD 2	Approximate
Physician/ Medical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	ACCIDE	VTAI		4 +	HIP	FR	ACTUR	E		Interval Between Onset and Death
Examiner			Due to (or as	a consequ	ence of):							
led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	ence of):				/			
be executed sician and burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequ	ence of):				1		Vi.	7/22/11
icate bu physic s the b	edical		d						\mathcal{L}	1		1 1 1)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal	death 3	Ectopic pregn Other (specify					Date of deli Month	very Day Year
res that the signed by	কু	Part II. Other significant condition	ns contributing to death b		-	nderlying cause			23e. Did to			the cause of death?
aw requi las been 2 shoul	Completed	RENAL FAI	LURE,						24a. Was	osy	prior to c	opsy findings available ompletion of cause of
n: The ficate h		25. Was case referred to medical	7	-		26	S. Place of Deat	h (Chook	1 🗌 Yes	rmed? 2 X No	death?	2 🗆 No
nysicia iis certi directo	To Be	examiner?	Hospital:	ient 2 🗆 I	ER/Outpatier		Other:		me 5 Resid	dence 6 \square 0	ther (Speci	(y)
ding Pl		27. Manner of Death 1. ☐ Natural 5 ☐ Pendin		iry y, Year)	28b. Time of injury 4:30A	V.	njuryat vork? □ Yes 2 🛣	- 1	28d. Describe h	ow injury occu		
Attender death	Certificate:	Accident Investig Suicide 6 Could r Homicide determi	not be 28e Place of Init	urv - At hor	me farm stre				28f. Location (S	Street and Nun	nber or Run	al Route Number,
pital or ours aft eral Dir filled in	cal C	29a. Certifier 1 Certifying	building, et At noi			accured at the t	ime date and r		Oldtown	, MD		Trail, SE
ne Hos n 24 hc ne Fun pleted	Medical	(Check 2 Medical E	xaminer: On the basis of a Nurse Practioner: To the	xamination	and/or invest	igation, in my or	pinion, death oc	curred at	the time, date a	ind place, and	due to the c	ause(s) and manner stated
		29b. Signature and title of certifier	(4)	122	1		ense number	1		29d. Date sign	ned (Month	Day, Year)
3		30. Name and address of person v	who completed cause of c	leath (Item.	23a) (Type, F		0064			<u>+ 1</u> MD 21	502	U
ros		31. Date filed (Month, Day, Year)					0	, GIIID C				
State Registra	-	uu 25 2011	Ma serial	A. 4	and							

			For State	State of M	larylar		epartment Certificate			Mental Hy		001	24942
			Registrar 1. Decedent's Name (First, Middle, L	l ast)			erincate	OI Death	11	2. Date of D	Reg. No	201	
	Physicia		James L. Arse	,						Month 0 7	Da 3	y Year	3. Time of Death 5:12 A M
	Medic Examir		4a. Facility Name (if not institution, g	give street and number)			4b. City, To	own, or Locati	ion of Death			. County of De	
	1		Franklin Square 5. Social Security Number 6	Hospital (Cente	ſ	Ro	sedal	le			Baltin	nore
	Funeral Director			6. Sex 7. Ag		ast birthd Yr	Months	Year If Un Days Hour	rs Min.	8. Date of B (Month, D	irth ay, Year)	9. B	irthplace (State or Foreign ountry) Vland
			215-46-8724 Usual Residence of Decedent		64	11	5.			110-18-	·1946	Mar	yland
	shov dat	tor	10a. State 10b. County		10c. Cit	y, Town o	r Location						10d. Inside City Limits
	Mary 28a-f otifie	irec		lto.			Notting	ham					1 Yes 2 No
	th the	a D	10e. Street and Number		•		10f. Zip C				10g. Cit	tizen of What C	,
	ms 2.	Funeral Director	2 Rosecrans P					1236	0-1-1-0 (0-	anif . Van au bla		USA	
(0	er dea or ite niner	y F.	11. Marital Status1 X Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	Ever in U.:	5.	 Was Deceder If Yes, specify 			Rican, etc.))-	14. Race - Am Black, Wh	
203	rs aft Iral", Exar	edk	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	. 110		1 🗌 Yes 2	X No Spec	cify:			Specify: W	hite
James 21215-0036	2 hou "natu	Completed by	15. Decedent's (Specify only highest	s Education grade completed)		16a. D	ecedent's Usual (Occupation	nost of worl	kina	16b. K	ind of Busines	s Industry
3 7	thin 7 ane. than	ĕ	Elementary/Seconday (0-12)	College (1-4 or	5+)	lif	e. DO NOT use re	etired)		9	c:	lothing	
d 2	ed wi Hygie other ent, tl	اما	17. Father's Name (First, Middle, Las	2		Sa	les	18 M	Inther's Nan	ne (First, Middle			
wult . Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	၉	James L. Arsena							nce Les		ourname)	
ا∞ ا <mark>ary</mark>	should and N is ma		19a. Informant's Name/Relationship	(Type, Print)			lailing Address (S	Street and Nui	mber or Rui	ral Route Numb	er, City or		
	nd 2 s ealth m 27		Daniel Arsenault	t	BRO				. Apt	. 1-D	Nott	ingham,	Md,.21236
Arsen altimore,	Page 1 a ment of H a nt: If ite ury or ott		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	B ☐ Removal from State	, 0	emetery,	isposition (Name crematory or othe	er place)		Date	20c. Lo	ocation - City o	r Town, State
Arsenault Iltimore, Maryla	permit. Page Department Important: I any injury o		4 Donation 5 Other (Spe		At:	Lanti	c Crema		8-4-			n Burni	
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Lice	ensee			22. Name and 9705 Be			Schimun Nottin			
			23a. Part 1. Enter the disease, or co	omplications that cause	d the deat	h. Do not						, Mu. Z	Approximate
	Physician/		shock, or heart failure. List only Immediate Cause (Final	y one cause on each lin	e.	h							Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as		lence of):							
	Examiner	_	Sequentially list conditions.				ntion						
	sit sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):							
	ecute and I-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):							
09	certificate be executed anding physician and use as the burial-transit	dical Examiner		d									
376	ificate ig phy as the	Med	IE ECNALE.	- 0.									
Box 687	h cert tendin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregna	ncy al death	3 🗆 Ectopic pre	egnancy				23d. Date of d	,
Bo	the att	Physician/Me	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown			5 Other (spec	cify)			T	Month	Day Year
P.O.	nat the ed by detach		Part II. Other significant conditions	s contributing to death t	out not res	ulting in t	ne underlying cau	use given in P	art I.	23e, Did	tobacco u	ise contribute t	o the cause of death?
<u>S</u> , F	ires the signer of the signer	d by								1 🗆	Yes 2	□ No 3 □	Probably 4 Unknown
ord	v requ	Completed								24a. Was	s an	24b. Were a	utopsy findings available
3ec	he lavite has	lmo								per	opsy formed? 2 XNo	death?	completion of cause of
a	ian: T irtifica stor, p		25. Was case referred to medical examiner?					26. Place of [Death (Chec		2 J23-INC		S Z PA INU
Ξ	hysic his ce	၉	1 Yes 2 No			ER/Outpa	atient 3 DOA	Other: 4	Nursing H	ome 5 🗆 Res	idence 6	Other (Spe	cify)
Jοί	ling P	Certificate:	27. Manner of Death 1. Natural 5 Pending	28a. Date of inju (Month, Da	ry y, Year)	28b. Tim inju	y	. Injury at work?		28d. Describe	how injury	y occurred	
Sion	death death ctor: /	ļįį	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	t be	In/ - At ho	me farm	M street factory o	1 Yes 2	? ☐ No	29f Location	(Street on	d Number or O	ural Route Number,
Division of Vital Records,	al or A s after I Direct		4 Homicide determine	building, etc			Street, factory, o	ance			wn, State)		arar Adute Muniber,
_	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Pl (Check 2 Medical Exa	hysician: To the best of	my knowl	edge, dea	ath occured at the	e time, date a	nd place, a	nd due to the c	ause(s) an	d manner as s	tated. cause(s) and manner stated.
	the H thin 24 the F mplete	— r	only one) 3 Certifying Nu	urse Practioner: To the			ge, death occurred	d at the time, o	date and pla		he cause(s	and manner a	s stated.
	5 . № 6 .		29b. Signature and title of certifier	ili N	•			icense numbe			29d. Dat	te signed (Mon	th, Day, Year)
	'	-	30. Name and address of person who	o completed acres of	J aath /lan-	220\ /5-		ESOC	100	()		//31	12011
16V			D II Ai	o completed cause of a			in Squa	rp. Dri	:10,	Baltim	oro	MD 2	17.37
	Stat	-	AUG 0 5 20		ar's Signa	ure	are				010	11/2	V.1
	Registra	ır	700 0 0 ZU	Kenna	1 19	9	arke						

		•	For State Registrar	State of M	iarylan	d / Depa <i>Cer</i>	artmen <i>tificate</i>	t of H	ealth a eath	and M		giene Reg. No		24943	
	Dhysisis	,	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea		y Voor	3. Time of Death	
	Physicia Medic		ELY	ADLE	R						AUGUST	03	, 201	1 11:35 A ^M	
	Examin	er	4a. Facility Name (if not institution, give	e street and number)			,	,	_ocation o				County of Dea		
Super			15101 INTERLACE 5. Social Security Number 6.5			ast birthday)	S] If Under		SPR.		0 D-1- (4 D)-1		MONTGO		_
	Funeral Director		075-05-9743	Sex IX M 2 □ F	92	Yrs.	Months	Days	Hours	Min.	8. Date of Birt 02/16/		9. C	irthplace (State or Foreign ountry) CT	
	*		Usual Residence of Decedent		, , ,			1			02/10/				
	shord at	ţo	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits	
	Mary 28a-f otifie	irec	MD MONTO	GOMERY		SILVER	SPRI	NG						1 ☐ Yes 2 🛣 No	
	a or be no	Q E	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	Country?	
	h with	Funeral Director	15101 INTERLACE					2090					USA		
	r iten iner		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Ves 2	Ever in U.S	3. 13. V	Vas Deced Yes, spec	ent of His ify Cuban	panic Orig , Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh		
36	after al", o xam	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	l No	1	☐ Yes	2 X No	Specify:				Specify:	WHITE	
21215-0036	within 72 hours after death with the Maryland giene grethen "natural", or items 23a or 28a-f sho er than "dedical Examiner must be notified at the Medical Examiner.	Completed	15. Decedent's I			16a. Deced	lent's Usua	1 Occupat	tion			16h. K	ind of Busines		1
215	n 72 h an "n Med	E I	(Specify only highest g Elementary/Seconday (0-12)	rade completed) College (1-4 or	54)	(Give I	aind of wor NOT use	k done du		of workir	ng	100.10	ina or Daomoo	o industry	
212	withii giene er th the		12	College (1-4 of	5+)	SA	LES					F	URNITU	RE	
pu	filed al Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Surname)		
yla	ld be Ment arke	유	PAUL		ADLE	R			SOP	HIE				FOX	
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med		19a. Informant's Name/Relationship (1	_	•			Route Numbe				
	ind 2 fealth im 27 her tu	3	LORRAINE ADLER/	WIFE					HEN I	DR,	∦707 , S			NG, MD 20906	_
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	Removal from State		lace of Dispo emetery, cren)	D	ate	20c. Lo	ocation - City o	or Town, State	
ij	t. Pag tmen tant: ijury	١,	4 Donation 5 Other (Spec	**	MT.	CARME					4/2011		LENDAL		_
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service Licer	see THE										., INC.	
		2. (i)	23a. Part 1. Enter the disease, or con	course that assess	d the death						ROAD, P		VILLE,	1	_
			shock, or heart failure. List only	one cause on each lin	e.	i. Do not ente	r trie mode	or aying.	, sucii as t	cardiac o	respiratory an	rest,		Approximate Interval Between Onset and Death	
	Physician/ Medical		disease or condition resulting in death)	a	NG CA									1 MONTH	_
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):									-
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Box 687	eath certifica attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnar	ncy Ideath 3 🗆	Ectopic p	regnancy					23d. Date of d		
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ita	Physician: The this certificate I ral director, pag	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:				Other	ce of Deat						-
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Σ	al or s afte			building, et	c. (Specity))				- 1	City or Tow	n, State,)		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 A Certifying Phy (Check 2 Medical Exam	rsician: To the best of	my knowl	edge, death o	ccured at	the time,	date and p	olace, and	d due to the ca	use(s) ar	nd manner as s	stated. e cause(s) and manner stated	- d
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			> Im an					D24	543			Αl	JGUST 3	, 2011	_
0			30. Name and address of person who	•		, , , , .	,		D	_				20006	
	24450	S (MIT)	JAMES A. ROSSI, 31. Date filed (Month, Day, Year)	M.D., 33			KE W	KLD	BLVD	., S	LLVER S	PRI	NG, MD	20906	_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g918 8-8-11 vt
State of Maryland Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ MARY MAY TIER BRISCOE August 2 7:02 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CATERED ASSISTED LIVING COCKEYSVILI Cockeysville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Year 1 - M 2 XF Hours 92 **Director** 219-03-2529 Maryland 1919 May Usual Residence of Decedent or 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🌠 No Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1025 Overbrook Road 21239 **USA** within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H John Barton Tier Mary Ellen Hipkins Jege 1 and 2 sh. Jeger 1 and 2 sh. Jeger 1 and 2 sh. Jeger 1 and 2 sh. Jeger 1 and 1 sh. Jeger 1 and 1 sh. Jeger 1 and 1 sh. Jeger 1 and 1 sh. Jeger 1 and 1 sh. Jeger 1 and 2 19a Informant's Name/Relationship (Type, Print)
Edward
Richard Briscoe, Jr. (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Overbrook Road, Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State Dul. Valley Mem Grdns 8/6/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signatur) Fuer vervice Dog.

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner menti Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): iding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pendina work' 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deatl Funeral Director: the 6 \(\subseteq \text{Could not be} \) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pleted filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie person who completed cause of death (Item 23a) (Type, Print) N. Chris Lewis 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend 5-22 per f.h. g918 8/5 chtil thate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 06:13 AM MICOLE PORIA (1)4 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ARBOR BALTIMORI If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral (4912/1 Year) Nig n/a Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at show MD. Baltimore 1x Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 3 r must be n 1716 Normal Ave. 21213 United States Funeral death v r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Ó infant infant Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ricky Bryant Erica Inobinett ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Erica Bryant/ Mother 1716 Normal Ave., Baltimore, Md. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2XICremation 3 ☐ Removal from State Department Important: If any Injury or once. Metro Crematory, Inc. 4/4/11 Catonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Scott A. Ruddick (per DVR) Kirkley-Ruddick F.H. 421 Crain Hwy., S.E. 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) XIREME Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (pries a consequence of) Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 (XInpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital or within 24 hours a To the Funeral I 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

DHMH 17 Rev 1/2001

AUG 0 5 2011 Dentra B. Jakes

AdE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBOYEGA

31. Date filed (Month, Day, Year)

3001 SOUTH HANDVER STREET

BALTIMORE Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 70 Month Physician/ Year August (1:39 PM S Bower Helen Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 7415 Belmont Avenue Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Davs Hours Min (Month, Day, Year Director NC 238-24-5251 -23-1924 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 x Yes 2 ☐ No MD Baltimore 10f. Zip Code 10e. Street and Number 109. Citizen of What Country? Funeral 7415 Belmont Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 😾 Widowed 4 🗆 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with nand Mental Hygien ris marked other th Trucking Proprietor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Kennedy Wallace B. Stafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Yawmeter Drive Middleriver Maryland 21220 Sterling C. Bower 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 ament of ! 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 8-5-2011 Baltimore, MD Bayview Crematory 22. Name and Address of Facility Connelly Funeral Home of Dundalk, PA 7110 Soliers Point Rd Dundalk, MD 21222 M01176 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o meart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate ause (Final ease condition resulting in death) ancer Physician/ LUNA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (piecase or impury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death signed by the a d be detached t ☐ Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 certificate Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) funeral 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director; / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSKAJAPANEMD 29c. License number 29d Date signed (Month, Day, Year, 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

N.S. RajapaKER/M.D.

2835 Smith AV

2. Registrar's Signaure

5-203

Baltimore MD 21209

Property of	Ex	Med
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed	witchin 24 nouts arter death. To the Funeral Director: After this certificate has been signed by the attending physician and

Funeral Director Very 1 to 2 to 2 to 2 to 2 to 2 to 2 to 2 to	g. Birthplace (State or Foreign Country) Texas 10d. Inside City Limits 1 X Yes 2 No What Country? A. Ice - American Indian, ack, White, etc. Iy: Black Business Industry Home
Physician/ Medical Examiner 1. Decedent's Name (First, Middle, Last) Yvonne Elaine Brown - Carter 4a. Facility Name (if not institution, give street and number) Sival Hospital of Baltiwore 5. Social Security Number 46. County 57. Age (In yrs. last birthday) Months Days Hours Feb 19, 1960	year 201 3. Time of Death 11.47 AM Ity of Death 9. Birthplace (State or Foreign Country) Texas 10d. Inside City Limits 1 ⊠ Yes 2 □ No 1 What Country? A. Ice - American Indian, ack, White, etc. Iy: Black Business Industry Home
Medical Examiner 4a. Facility Name (if not institution, give street and number) Sival Hospital of Baltimore 5. Social Security Number 46. City, Town, or Location of Death 86. City, Town, or Location of Death 87. Age (In yrs. last birthday) 15. Months Days Hours Min. 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Social Security Number 46. City, Town, or Location of Death 46. County	g. Birthplace (State or Foreign Country) Texas 10d. Inside City Limits 1 X Yes 2 No What Country? A. ice - American Indian, ack, White, etc. iy: Black Business Industry Home
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Funeral Director 5. Social Security Number 453-39-9197 6. Sex 1 In M 2 In Security Number 5. Social Security Number 1 In M 2 In Security Number 5. Social Security Number 1 In M 2 In Security Number 5. Social Security Number 1 In M 2 In M 2 In M 2	Country) Texas 10d. Inside City Limits 1 X Yes 2 No What Country? A. Idea - American Indian, ack, White, etc. W. Black Business Industry Home
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Md. Baltimore City 10e. Street and Number 2811 Hemlock Avenue 282 Was Decedent Ever in U.S. Armed Forces 2 1 Never Married 2X Married 3 Widowed 4 Divorced 3 Widowed 4 Divorced Baltimore City 10f. Zip Code 21214 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Specify 1 Yes 2 No Specify:	What Country? • A • Ice - American Indian, Ice - Minister, etc. Ice - Black Business Industry Home
10e. Street and Number 2811 Hemlock Avenue 10f. Zip Code 21214 10g. Citizen of U.S. 11 Marital Status 1 Never Married 2X Married 1 Never Married 2X Married 3 Widowed 4 Divorced 10g. Citizen of 10g. Citizen of 10g. Citizen of 10g. Citizen of 10g. Citizen of 10g. Citizen of 10g. Citizen of 10g. Citizen of 11 Separate of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, Give 1 Yes, Give 1 Yes, Give	.A. Ice - American Indian, ack, White, etc. y: Black Business Industry Home
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Carren W. Carrer Husband 20b. Place of Disposition 20b. Place of Disposition August 20c. Location 20b. Place of Disposition 20b. P	- City or Town, State
1 Burial 2 A Cremation 3 Removal from State Ardent Cremation 5,2011 Hanove	er,Maryland
21. Signature of Funeral Service Lice Isee 22. Name and Address of Facility Kaczorowski Funeral Service Lice Isee 1201 Dundalk Avenue Baltimore	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Approximate Interval Between Onset and Death
Medical disease or condition resulting in death) Examiner disease or condition resulting in death) a. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):	
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25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 November 1 Page 1 No Other:	<u> </u>
The state of the s	
28d. Describe how injury occurry 28d. D	D. J. D. J. D. J. March
28f. Location (Street and Numb building, etc. (Specify) 28f. Location (Street and Numb City or Town, State)	per or Hural Houte Number,
The state of the s	ue to the cause(s) and manner stated.
29b. Signature and title of certifier 29c. License number 29d. Date signe 29d. Date signe	ed (Month, Day, Year) 28, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miles Milk autic MD Sugar Hassackal at Ralting by B	
State Registrar State Registrar State AUG 0 5 2011 Server 32. Register's Signature AUG 0 5 2011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barr Physician/ Month Illian 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner stminster IVING Date of bit... (Month, Day,) If Under 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min Baltimore, MD 218-14-1706 87 Yrs. **Director** 924 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified MD Carroll Westminster 1 Tes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 564 Marshall Drive 21157 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: White 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other trammer ပ္ Mildred A. Crout Stanley L. Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Barr- Son 2091 Coon Club Road, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Moreland Memorial 1 XBurial 2 Cremation 3 Removal from State Parkville, MD 4 Donation 5 Other (Specify) Park Sign ure of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Harford Rd. Parkville, MD / 3a. P / 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause _n each lin_. n each lin Interval Between Onset and Death Im ediate Cause (Final Ph_sician/ dis ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown as been siç 1 Yes 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death? autopsy performed page 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec Hospital Assisted 2 XN0 ျှ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 \square Pending 1 Yes 2 No M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature çause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

(Month, Day,

05

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Benny 22 25 M 31 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 215-22-1453 22. 1927 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once. 10h. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Director Maryland 10e. Street and Number Baltimore Dunda1k 10f. Zip-Code 10g. Citizen of What Country? Funeral 402 Trappe Road United States 21222

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Financia1 12 years Stock Exchange Auditor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Middleditch Nellie Jane Schaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joseph J. Benny, Jr.</u> 3819 Cedarbrooke Place Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/5/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Approx shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) days)/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of) the attending physician and ched for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ၀ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; Director: After this completely filled in by the hours after Funeral within 24

To the

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eland hristine V19 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

5 lenevas

ORIGINAL

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sylvia Ann Byrne Physician/ Mugust 2011 3:12P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Worcester 7703 Old City Road Whaleyville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 213-32-1169 **Funeral** 1 M 2 XF Months 76 06/23/1935 PΑ **Director** Usual Residence of Decedent 28a-f show Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD Berlin Worcester 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11003 Grays Corner Rd, #65 21811 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. "natural", or by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: White Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meral Cohick ျ Lewis Hogan 19a. Informant's Name/Relationship (Type, Print) Charles I. Byrne 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
11003 Grays Corner rd., #65, Berlin, Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Final Journey Crem. 8/3/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD llou Scan 1413, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIVE PHLMONAMY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** YPRATRUSION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes death? 2 X No 1 Yes 1 Yes To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After Natural work? 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 Huism Date filed (Month, Day, Year) State AUG 0 5 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1

			1 - For State Registrar		ar y loar i	Cei	rtificate of	Death		Reg. No.	2011	24900
			1. Decedent's Name (First, Middle, Last)			-			2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Lillian Bernade	th Colr	oss				July	25	2011	11:15P™
and a	Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o		eath	4c. Co	ounty of Death	
mad'			Harmony Hall				Co1um				Howa	
	Funeral		5. Social Security Number 6. Sex	7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Da	rth ay, Year)	Coun	
	Director		Usual Residence of Decedent		89	113.			May 28	, 1922	2 Penns	sylvania
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation				10	d. Inside City Limits
	Mary f sh	호	MD Howard			Co	olumbia					1 □ Yes 2xxx No
	the roun	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Count	try?
	3a o	교	6336 Cedar Lane	Apt#320			2	1044			U.S.A	
	death ms 2	Funeral		2. Was Decedent Armed Forces?	Ever in U.S	S. 13. \			(Specify Yes or No Jerto Rican, etc.)	o- 14	. Race - America	an Indian,
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Σ	shoul nd M marl marl	ř	19a. Informant's Name/Relationship (Typ	e. Print)		19b. Mailir	ng Address (Street		Rural Route Numb			Code)
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ē,	s 1 a		20a. Method of Disposition		20b. Pl		sition (Name of natory or other place		Date		ation - City or To	wn, State
E	Pages nent of I int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 15 ☐ Other (Specity)	emoval from State			leaven Ce		-28-2011	Rocky	ville, M	D
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service License	B)		22	2. Name and Addre		Witzke Fu		<u>.</u>	
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			23a. Part 1. En the diseas , or complice shock, or heart failur . List only one	ation Thi cause cause on each lin	the death	. Do not ent	er the mode of dyi	ng, such as car	diac or respiratory a	arrest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as	a consequ	ence of):		•				
	Examiner	L.	Sequentially list conditions, b.								- 2	
	sit sed	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury	Due to (or as	a consequ	ence of):						
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687	tificate I ng physi as the b	Medical	a.									
			IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome						23	d. Date of delive	ery
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ord	v require been si should b								_ 1 🗆	Yes 2	No 3□ Prob	ably 4 ☐ Unknown
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		등							perfo 1 □ Yes	ormed? 2 I No	death?	2 □No
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	spita nours neral		29a. Certifier 1 Certifying Phys	i cían : To the best	of my know	vledge, deat	h occurred at the t	ime, date and p	lace, and due to the	e cause(s) a	and manner as s	tated.
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in L	Medical	(Check only 2 Medical Examin one)	er: On the basis o and manner sta	f examinat ated.	tion and/or in	vestigation, in my	opinion, death o	occurred at the time,	, date and p	place, and due to	the cause(s)
	To the Comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
			// vs)			Dy	ノイナン		July	26.8	LOIL
			30. Name and address of person who cor	npleted cause of d	eath (Item	23a) (Type,		C 11.	1.2	Colu	1-10 11	Apry lond
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State Registrar

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Registrar

State of Maryland / Department of Health and Mental Hygien

Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 30 21:11 PM Lue Chumley 2011 121/ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A If Under 1 Year If Under 24 Hrs.

Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Apr. 10, 1921 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days 228-12-8895 90 **Director** VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County or 28a-f shov notified at 1 ☐ Yes 2 🔀 No Director Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or Examiner must be U.S.A. 21222 225 Ashwood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🙀 No Specify ģ Specify: 3 XWidowed 4 □ Divorced White "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation the Medical (Give kind of work done d life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Hospital medical technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berta Clay Ha11 ည Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4920 Lakewood Drive, Manhattan, KS 66503-8402 Item 27 Forrest G. Chumley(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Vernon Bapt.Cem Aug. 5, 11 Axton, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Charles S Zeiler & Son. Inc. 6224 Eastern Ave. Baltimore, Maryland 21224 MOUSOY Approximate Interval Between Onset and Death and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Complications of Pneumonia **Physician** 4 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records. eq 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has! rmed? 2 No 2 No 1 TYes 1 Tes 25. Was case referred to medical examiner? filled in by the funeral director. 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 July 30, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea C. Baines, M.D. 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month Day Year) AUG 0 5 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 209 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town Kandellst If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🏻 F Months Days Hours March, 17% Mary Land 220-36-1898 Yrs. Director Usual Residence of Decedent or 28a-f show notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 Elizabeth Road 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Taylor Elizabeth Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa McNair / Daughter 2813 Gray Antler Ct. Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1 Durial 2 Carcemation 3 Removal from State 2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremetion Service — Bel Air 3 Newport Drive Forest Hill, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartifature. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Je Physician/ disease or condition Medical resulting in death) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🐼 No Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 K No 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of SI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

Registrar

5 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 🛭 📗 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 4:40 P M Charles Andrew DeMarco 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9808 Winding Trail Dr. Worcester Ocean City Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 1**X** M 2 □ F 81 10718 Director 212-26-1599 T929 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9808 Winding Trail 21842 USA Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify Specify. Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Architect Architecture permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pasquale Charles DeMarco Elizabeth Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2184 Doris DeMarco / wife 9808 Winding Trail Dr., Ocean City, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral Cem! 8/3/2011 Baltimore MD 22. Name and Address of Facility Homes, 21. Signature of Funeral Service Lice Inc. Columbia. 5555 Twin Knolls Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions. Examine Directo for as a non-sequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perform this certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work?
1 Yes 2 No of Funeral Director: Af eleted filled in by the funeral process. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person SAUSBURY 550 32. Registrar's Signature State AUG 0 5 201 Registrar

Registrar

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		1	For State Registrar	tate of Maryland	Cer	tificate	of De	eath	Re	g. No.		
	Physicia	n/	. Decedent's Name (First, Middle, Last) Ida Mona Dick	ev					2. Date of Death Month July 29	Day	Year	3. Time of Death 2:25 A ^M
	Medic Examin	_	a. Facility Name (if not institution, give stree			, ,		ocation of Death		4c. County		
			7315 Wenig Ave.		1 6 1-11-1-1	Dun If Under	dalk	If Under 24 Hrs.	8. Date of Birth		imore 9. Birthp	lace (State or Foreign
Ħ	Funeral Director		213-34 - 1929	7. Age (In yrs. las	Yrs.	Months	Days	Hours Min.	(Month, Day,) 02/14/19	Year) 936	Count	sylvania
	land show dat	l. h	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	Mary 28a-i otifie	Director	MD Baltimore	Dund	alk	10f. Zip	Code		1	0g. Citizen of	What Coun	
	with the 23a or 1st be r	Funeral D	10e. Street and Number 7315 Wenig Avenue			21	222			United	Stat	es
	leath items ier mu	E.	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. \	Was Deced	lent of His	panic Origin? (Spe , Mexican, Puerto !	cify Yes or No- Rican, etc.)		ce - Americ ick, White,	
38	al", or	d by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.		1 🗌 Yes	2 🙀 No	Specify:		Specify	Wh	ite
2-0	natur dical E	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a. Dece	kind of wo	rk done di	ition uring most of worki	ng	16b. Kind of E	Business In	dustry
121	thin 72 me. than than	ğ	Elementary/Seconday (0-12)	College (1-4 or 5+)		o NOT use mbler				Manuf	actur	ing
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au	be fillental rked c	욘	William C. Nicewong	ger					E. Bergq			
lary	should and M is mai		19a. Informant's Name/Relationship (Type,	***************************************	19b. Maili	ng Address	s (Street a	nd Number or Rura Road Dund	al Route Number,	City or Town, 2122	State, Zip	Code)
<u>დ</u>	and 2 lealth sm 27 ther tr		Joy Shea (Daughter) 20a. Method of Disposition	20h Pi	ace of Dispo					20c. Location		own, State
nore	age 1 aent of H		1 Burial 2 □ Cremation 3 □ Rer Donation 5 □ Other (Specify)	moval from State	emetery, cre ly Hil	matory or o	ther place		2-2011 N	Middle	River	, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Litensee	1/1-				Funeral Avenue D	Home of	Dundal Maryla	k Ir	222
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	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ience of):			,				
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Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physic ral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	:. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	I death 3	☐ Ectopic	: pregnanc specify) _	cy		1	Date of deli Month	very Day Year
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Re	ician; The certificate rector, pag		25. Was case referred to medical				26. P	lace of Death (Che		2 X No	I 🗀 Yes	2 110
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Division	To the Hospital or Attending Physician, within 24 hours after death. To the Funeral Director. After this certific completed filed in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, s	M street, facto		Yes 2 No	28f. Location (S City or Tow	Street and Nur vn, State)	mber or Ru	ral Route Number,
۵	Hospital 24 hours a Funeral E	Medical (lan: To the best of my know r: On the basis of examination Practioner: To the best of m								
	To the within 2 To the сотрые	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	TOURONO, TO THE DEST OF IT	,	2	9c. Licens	se number		29d. Date sig	gned (Monti	n, Day, Year)
	->-0		> Korest Bu	A			1739	the		July 2	29, 2	011
	OSM		30. Name and address of person who cor	npleted cause of death (Iter	n 23a) (Type	e, Print)	altiv	neve, W	ND 21-	219		
	St	ate	31. Date filed (Month, Ray Gar) 5 20	npleted cause of death (Iter	ature).	park			19			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12.30 PM 29 2011 obert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner N/A Saltimore Lite topkins HOSPITA ohns 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 50 225-94-3186 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene. Important: jor items 23a or 28a-f show any injury or other traumatic event, the Modical Exit ciner must be notified at 1 ☐ Yes 2 X No Director Rosedale Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7105 E. Biddle Street 21237 United States Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after T XYes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√∑No Specify 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Elevator Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ' Elizabeth Ann Clark Duty Charlie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7105 E. Biddle Street Baltimore, Maryland 21237 Lolita F. Duty (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 08-03-2011 Rossville, Maryland 4□Donation 5 MOther (Specify) Entombment 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licen 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 100 azcinoma /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending phohed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year n signed by the a 5 Other (specify) ☐Yes 2 ☐ No 9 ☐ Unknown 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No illed in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a

To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier RES-000 July 00, N. Wolfe Street, address of person who completed cause of death (Item 23a) (Type, Print) 30 Name an DHAVAL 31. Date filed (Month, Day, Year) State AUG 0 Registrar

			1 - State of Maryland / Dep	partment of Health and ertificate of Death		ene 3. N 2 0 1 1	24961		
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Earl Daniel		2. Date of Death Month		3. Time of Death		
	Medic Examin		4a. Facility Name (if not institution, give street and number) Multi- Multical Center	4b. City, Town, or Location of Deat	V	4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 6. Sex 1 St M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth Cour 1919 West	place (State or Foreign htry) Virginia		
	and show dat	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
Baltimore, Maryland 21215-0036	ie Maryl r 28a-f notified		Maryland Baltimore Baltimore Baltimore	ore 10f. Zip Code	10	g. Citizen of What Cou	1 Yes 2 No		
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aryl	should be file n and Mental I 7 is marked o raumatic eve		William Hinton Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ru		ity or Town, State, Zip	Code)		
e, M	and 2 s Health s em 27 i		Elsie Christine Daniel (Wife) 8027 20a. Method of Disposition 20b. Place of Disp			Maryland :			
mor	Page 1 an ent of Hant of Hant of Hant of Hant or of Urry or of		1 Burial 2 Cremation 3 Removal from State cemetery, cre	ematory or other place)		oc.Location - City or T altimore, l			
Balt	permit. Departri Importa any inju		21. Signature of Funeral Service Linds ee	22. Name and Address of Facility Duda—Ruck Funeral 7922 Wise Avenue	Home of I	Oundalk, In	nc. 21222		
	hysician/	X Z	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	livary gland					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ural effusion		1			
	xecuted al-transi	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last c. Pul monum Due to (or as a consequence of): d. Peri chridial	pertension					
09/	eate be executed physician and the burial-transit	edical	La <u>Pericardial</u> e	ffusion.					
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv	very Day Year		
. P.O.	is that th gned by be detac		Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
ords	v require s been s should	oleted	thypertensism chronic obstructive pulmonary	1 ∐ Yes 24a. Was an	24b. Were auto	ppsy findings available			
Rec	The law cate has page 2	Completed	1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No						
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Che ent 3 □ DOA Other: 4 🕅 Nursing I		ce 6 🗆 Other (Specif	v)		
Division of Vital Records,	iding Phy ith: After this funeral o	Medical Certificate: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year) injury		28d. Describe how injury occurred				
	al or Atte s after de: li Director d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ne Hospitt in 24 hours ae Funera pleted fille		29a. Certifier 1	stigation, in my opinion, death occurred	at the time, date and ;	place, and due to the ca	use(s) and manner stated.		
	To the within the come come		29b. Signature and title of certifier A-13855, MD	29c. License number D 71493	290	d. Date signed (Month, 8 - 2 - 11	Day, Year)		
¥	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Favah Bozors: 7700 York Rd Towsan, 701d 21204						
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 5 2011 32. Pegistrar's Signature	in Hal					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Janet Physician/ Heilman Doering Month 11:30PM 2011 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince George's Examiner 4b. City, Town, or Location of Death 11905 Schantilly Lane Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 218-82-7845 1 □ M 2 😿 F 93 Months Days Hours Director /06/1918 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George Mitchellville notified 28a-f 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a USA 20721 11906 Progress Lane 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iter Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural" 3 ₩ Widowed 4 □ Divorced Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the alth and Mental Hygie 27 is marked other r traumatic event, tt Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Odher ည Othe W. Heilman Greta Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 11906 Progress Lane, Mitchellville, Janna Zuber/Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey crem. 8/8/2011 Woodbine, MD Signature of Funeral Service License Corota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD, 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 7040 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Dav Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 performed? Yes 2 No certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဨ ER/Outpatient 3 DOA 1 Inpatient 2 I this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Apspital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Image: In the least of examination and/or investigation, in words of the time, date and place, and due to the cause(s) and manner stated.
2 Image: In the least of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Image: Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
AUG 0 5 2011

Box 68760

P.O.

Records,

Division of Vital

North

Housen Ch Su'K

, MO

4175

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 926 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Y 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Year 1941 Maryland 1 X M 2 🗆 F Months Days Hours Min. **Director** 69 218-40-8751 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 28a-f 1 🗆 Yes 2 📉 No Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10531 Tolling Clock Way 21044 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceuent 2. Armed Forces?
1 ☐ Yes 2 ▼ No Race - American Indian traumatic event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: Specify. White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Computers Be ment of Health and Mental Hy ut: If item 27 is marked by y or other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be William J. Daley Wilamena M. Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 East Lake Drive, Annapolis, Maryland 21403 Gillian Conner / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Metro Crematory Inc. 08/03/2011 | Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. 28a. Date of injury (Month, Day, Year) 27. Manner Peath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral I Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00070693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 53 MAHBOOB SYED

DHMH 17 Rev 7/2009

State Registrar 0 5

32. Registrar's Signature

Unk Unk	EC		1- For State		aryland / Depa		ealth and Ment	al Hygiene	2011	24964
	hysici		Registrar 1. Decedent's Name (First,	Middle Last)	-	Titlicate of D		2, Date of Dea	eg. No.	3. Time of Death
Medical	⊏xamı	ner	4a. Facility Name (if not ins	titution, give street	and number)	4b. (City, Town, or Location o	Month August 2,	2011 4c, County of Death	0125 hrs
E.			Johns Hopkins H	ospital 6. Sex	7. Age (In yrs.		altimore Under 1 Year If Under	24Hre 8 Date of Bir	th(MM/DD/YYYY) 9. Bird	hnlace (State or
	ineral rector		A1A		F 7. Age (III yrs.		Months Days Hours	Min. 5-17	Foreig	
	any		Usual Residence of Deced		10c. City	, Town or Location				10d. Inside City Limits
land	f show a	ō	MD		B	altim	oro)			1 Yes 2 No
he Mary	he Mary or 28a- ified at	Director	10e. Street and Number	Com	nc 1, 10,	10	a UI2	1	Og. Citizen of What Cour	ntry?
th with 1	ems 23, t be not	Funeral	11. Marital Status 1 Never Married 2		/as Decedent Ever in U		ecedent of Hispanic Origi specify Cuban, Mexican,		- 14. Race - Ameri White, etc.	can Indian, Black,
ıfter dea	l", or it	by Fur	3 Widowed 4	Divorced or Date	Yes 2 No	1 Ye:	s No specify:		Specify:	aclo
2 hours a	"natura Exami	ted b	15. Decedent's Education	(Specify only higher			Isual Occupation (Give k of working life. DO NOT L		16b. Kind of Business/I	ndustry
036 vithin 72	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once,	Completed	12 4		110g0 (1 7 51 5 1 7	SelF	EMPLO	red	Ativo	fe
215-(Be Co	17. Father's Name (First, M	liddle, Last) Word E	anes I	-	(18.Mother's	s Name (First, Middle, M Manhha	Maiden Surname) - G · Jac	Kson)
MD 21	and Mer 7 is mar	٥	9a. Informant's Name/Rela	ationship (Type, Pri	int (Father)	19b. Mailing Ad	dress (Street and Numb		nber, City or Town, State	
re, M	Health Fitem 2 er traun	•	20a Method of Disposition Burial 2 Crer		20b.	Place of Disposition crematory or other p	(Name of cemetery,	ges Au	20c. Location - City or	
Baltimore,	rtant: I		4 Donation 5 Oth	er Specify:	A A	Thutus	Cemerery	8/8/2011	Baltino	re, MO
B permi	In po		21. Si thature of Europe Se	OISS =	3	Vau	and Address of Padilly	Pd B	Oto MD	LIZIZ
	ician dical		failure. List only one of	cause on each line.	s that caused the death		ode of dying such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Exar	Examiner		Immediate Cause (Final dis or condition resulting in dea		or as a consequence of					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying C	Due to (or as a consequence of	of):				
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e executed	rian and rial - transit	dical	UNPENDED	d. AMEN	4DED					
3760 , ificate b	30x 68760, death certificate be attending physicil for use as the buri	n/Mec	IF FEMALE: 23b. Was decedent pregnan	t in the	If yes, outcome of preg	gnancy 2 Fetal d	eath 3 Ectopic	pregnancy	23d. Date of delivery	ay Year
Box 68760, e death certificate b	attendir for use a	Physician/Me	past 12 months? 1 Yes 2 No 9	4	Pregnant at time of de	aath -	(Specify)			,
.O. B hat the d	etached	by Phy	Part II. Other significant co			resulting in the under	lying cause given in Part		bacco use contribute to	_
Division of Vital Records, P.O. and or Attending Physician: The law requires that the control of the law requires that the control of the law requires that the control of the law requires that the control of the law requires that the control of the law requires that the control of the law requires that the control of the law requires that the law requires the law requires the law requires that the law requires the la	cords, P.O. E aw requires that the d as been signed by the 2 should be detached	ted b						1 Yes	2 ✓ No 3 Prob an 24b. Were au	ably 4 Unknown
ecor he law r		Completed						autop: perfor	med? death?	ompletion of cause of
ital R	s certificate rector, page	8	25. Was case referred to me examiner?	edical Hospital:	4 Investigate 2 A	ER/Outpatient 3	26.Place of Death (C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
of V	After this funeral di	n: 70	1 Yes 2 No	28a	i. Date of Injury (Month, Day Year) IQ 1, 2011	28b. Time of Injury			now injury occurred	
Sion	ctor:	catio	Natural 5 2 Accident	Investigation 284		2322 hrs	1 Yes 2 1 tory, office building, etc.	VO -	street and Number or Ru	ral Route Number, City
Div	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that he death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 ☐ 4 ✔ Homicide	Could not be	pecify) Local Stree		otory, ottoo bullonig, oto.	or Town, S		
J. H		Medical		Examiner: On the	basis of examination a				e(s) and manner as state and place, and due to the	
e i	S I S	Me	29b. Signature and title of co		nner stated.	A	29c. License number		29d. Date signed (Mor	th, Day, Year)
		}	30. Name and address of pe	2000 who complete	ed cause of death (Item	123a)	O.C.M.E.		August 2, 2011	
6			Zabiullah Ali, M.D.	100	Medical Examiner	180	more Street, Baltin	nore, MD 21223		
	St Regist	ate rar	31. Date filed (Month, Day,)		Dawn Signal	. park				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 24965 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 28^{Day} Physician/ $J_{\mathbf{u}}^{\mathsf{Month}}$ 20^{Year}1 1:00 PM_M Patricia Ann Espenshade Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard 5580-1 Vantage Point Road Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 08-26-1941 1 M 2 X F Pennsylvania 206-32-1027 Yrs **Director** 69 Usual Residence of Decedent 28a-f shov 10b. County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5580-1 Vantage Point Road 21044 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Agriculture Network Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ruby Campbell Lester Walters permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Harvey Street Baltimore, MD 21230 Mark R. Espenshade (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State cemetery, crematory or other 07/31/2011 Laurel, Maryland Baltimore Wash. Crem. 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licen-22. Name and Address of Facility Witzke Funeral Homes, Inc Road Columbia, MD 21045 MU1283 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final OP Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linju that initiated events resulting in death) Last and Due to (or as a consequence of): nding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 \(\text{Nursing Home} \) 1 Nursing Home | 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: _2 **X**No မ this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident the 24 hours after dec Funeral D rector Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only on 29c. License number 00009526

Registrar

5

Suite104, Columbia, MD 21044

(Item 23a) (Type, Print)

			1 - State Registrar	State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No.							1 24966
	Physici	an.	Decedent's Name (First, Middle, Last)			+ \			Date of Death Month	Day Yea	3. Time of Death
-	/Medi	cal	ANNA			EY			D8 (52 20	
	Examir	ner	4a. Facility Name (If not institution, giv 3926 North Point			_	wn, or Location of	of Death		4c. County of De	
	Funeral		5. Social Security Number 6. S		ast birthday)	Dund If Under 1 Y	ear If Under		Date of Birth	Baltime 9.8	ore Birthplace (State or Foreign Country)
	Director		217-16-0845	□ M 2□XF 87	Yrs.	Months D	ays Hours		Month, Day, Ye	3.6	country)
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c Cib	, Town or Lo	cation			5 23,	1723	10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Exerticet must be notified at	Director	,								1 Yes 2 No
			Maryland Balti 10e. Street and Number	more D	unda1k	10f. Zip Co	de		10g	. Citizen of What	21
		a D	3926 North Point	Road		21	222		I	nited St	ates
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36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		I□Yes 21√2			, ,	Specify:	11110, 010.
9	tural	ed p	15. Decedent's E	Year or Dates:	16a, Deced	ient's Usual O	ccupation		161	o. Kind of Busine	White
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att	permit. Pag Department Important: I any injury o		21. Signature of uneral Service Licer		22	Name and A	ddress of Facilit	V		undalk,	
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	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a VASCUL		DEME	AITINE				5 YEARS
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	C	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	vledge, death	occurred at th	ne time, date an	d place, and o	tue to the caus	e(s) and manner	as stated.
	he Ho n 24 } he Fu oletely	edic	(Check only 2 Medical Examone)	niner: On the basis of examinati and manner stated.	ion and/or inv	estigation, in r	my opinion, deal	th occurred at	the time, date	and place, and o	lue to the cause(s)
	To the leadth within 2. To the leadth complete	Σ	29b. Signature and title of certifier	0.		29c. Lie	cense number		29d.	Date signed (Mo	onth. Day, Year)
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			30. Name and address of person who				Cx.	10	Rall	more,	MD 2 mai
/90	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		ayne	un Cir	CIE	POULT	11core	0100
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24967 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth 2100 Mary Clare Bonham England ust 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Assisted Living -The Meadows Sandy Spring lontgomen Social Security Number 6. Sex If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 1 T Hours 1072771922 Country) Director MD 88 577**-**26-5892 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits by Funeral Director MD Montgomery Sandy Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1641 Hickory Knoll Road 20860 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXIo Specify 3 Widowed 4 Divorced Completed Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Library 5+Librarian traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Stoltenberg Robert Bonham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 10815 Kingstead Road Damascus, MD 20872 Mark B. England, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/4/2011 Beltsville, MD 21. Signature of Funer | Septical Lice 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Olyonic obstructive disease or condition ears Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No Month Year signed by the a d be detached f 1 | Yes 22 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dementia; acute appitis; history Division of Vital Records, 1 Yes 2 No 3 ☑ Probably 4 ☐ Unknown been si Completed ischemic attacks transient 24b. Were autopsy findings available 24a. Was an certificate has b lirector, page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specif the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D42046 ade School Road Sar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooke Huffman 18100 S

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 5 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24968 State of Maryland / Department of Health and Mental Hygiene 2011 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day} 2<u>011</u> Physician/ Robert Maynard French Sr. August 6:37 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2644 Conowingo Road Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 8, 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 1 XM 2 - F 1922 Virginia Director 228-12-4006 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2644 Conowingo Road USA 21015 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

Yes 2 \[\sum \] No Black, White, etc. "natural", or ģ 1. Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Minister Religion Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Docie Belle Sheets Thomas George French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn M. French / Wife 2644 Conowingo Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 8-5-2011 Oak Grove Bapt. Chr. Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ CONGRESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown 9 Unknown isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should by 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-Z-ZO(1 152279 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALASUBRAMANIAN 2021 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2, 2011 tana Lee GOODWYN Mildred 10:20a4 AUGUST Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 🗜 Days Hours 221.20.4894 78 **Director** NC Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Reisterstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 Funeral Homevale Ruad USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify: Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Ith and Mental Hygien 27 is marked other the r traumatic event, the 12+12 grade vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seth Enoch Griffin Bowe trmeicy ファしつのに of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Kenee Epps/Daughter Humevale hoad Reisterstann MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2011 Owings Mills, MD Garrison 21. Signature of FunerahService Licensee 22. Name and Address of Facility Muchin 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Infinal April 1997 December 1997 De Interval Between Onset and Death PARUMOPERITORRUM Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): 055: Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury VOIVUIUS PRCAI -transit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a thed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 1 Yes 2 19 Unknown Yes 2 No 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part DENCYLA DE PEDBABLE ALZNONE! 23e. Did tobacco use combibute to the cause of death? Completed by AIZNOM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 2 No 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only o License number P N. Charles 32. Registrar's Sig

Registrar

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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 Never Marr3 Widowed		d 1	as Deceder med Forces Yes 2 (Yes, Give ear or Dates	X No	If	Vas Decede Yes, speci	fy Cubar	n, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)			ck, White,	can Indian, etc. ite
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2	☐ Certifying Pl☐ Medical Exa X Certifying N	miner: On	the basis of	examination	n and/or investi	gation, in m	y opinior	n, death or	ccurred at		and place	e, and du	ie to the ca	ause(s) and manner stated
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fammon Month B Physician/ Year 2011 Day James 3:57 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Nursing Home Montgomery Chevy Chase If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 01/30/1934 1 🔀 M 2 🗆 F Hours 494-34-9774 Director Towa Usual Residence of Decedent s 23a or 28a-f show rust be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hyglene. It and If Item 23a or 28a-f sho tant if Item 27 is marked other than "natural", or items 23a or 28a-f sho irry or other traunatic event, the Medical Examiner must be notified at jury or other traunatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5600 Wisconsin Ave., Unit 308 20815 USA "natural", or items 23 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced Completed White Year or Dates ll Hygiene. I other than "nature vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Tench Temme Gammon Helen Delores Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5600\,$ Wisconsin Ave., Unit 308, Chevy James Gammon / Self Chase 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important; If ite
any injury or ott
once, Date rinal Journey crem. 1 Burial 2x Cremation 3 Removal from State 8/5/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ malnutcition Failure Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₺️No ((Stones 24a. Was an autopsy performed? Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 L No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I

Registrar DHMH 17 Rev 7/2009 29a, Certifier

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31. Date filed (Month, Day, AUG 0 5 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8700

Jones Mill

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Chevy Chase, mp 20815

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year 2 - 3 -6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 214-38-908 **Director** West Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 1 Yes 2 No Director ms 23a or 28a-f s must be notified 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 21224 8013 Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear. Department of Health and Mental Hygiene. Important if Item 27 is marked other them any Injury or other traumers. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ 4 Divorced 3 Widowed White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2035 ODINS 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BAHMORE, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Oscpk 2635 an complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart failure only one caus ach line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Electronic Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and d for use as the bunal-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 mg Day 5 Other (specify) ate has been signed by the a page 2 should be detached 2 P.O. Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 2 No 3 Probably Completed 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director; After this certificate has 2 🗆 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home \(\sum 5 \sum \) Residence Yeş ER/Outpatient 3 DOA မ 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation the Hospital or Attending Natural (Month, Day Year) 1 🗌 Yes 2 🗌 No death. Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours after To the Funeral Direc City or Town, State) 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 29b. Signature and title of certifier 30. Name and add vho completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32 istrar's Signature State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 11,12,15-17,19a,b,20a,21-22 per fh.23a per doc g918
State of Maryland / Department of Health and Mental Hygiene 20 2 State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 47 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6. Sex 1 ☑ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth If Under 1 Year Social Security Number Birthplace (State or Foreign Country) LTIK **Funeral** Sept 25, Days Min. 219-38-9382 68 Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code 21223 1217 W. Fayette St. 11. Marital Status unk 12. Was Decedent Ever in U.S. UH Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. black δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Frank Hall Rosetta Moore 19a. Informant's Name/Relationship (Type, Print)
Jenea Hall Daughter
Bon Secours Hospital 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore St; Baltimore, Maryland Ellamont 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 Cother (Opecify) 11 State cemetery, crematory or other place) MetroCrem/Balto.Nat. 8/2/11 Baltimore, MD 22. Name and Address of Facility James Anatomy Board

25. W Baltimore St. Baltimore, Som Selection St. Baltimore, Som Selection St. Baltimore, St. Baltimore, St. 21217 21. Signature of Funeral Service Scenses Wade, Director James A. Morton per dvr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Atrial Fibrillation Approximate Interval Between Onset and Death Physician/ MONAI disease or condition resulting in death) Medical Due to (or as a conseque e of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused to the Attention of the Attent inding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 N 2 🗀 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director examiner?
1 🗌 Yes 2 🗷 No Other: 4 \(\supers\) Nursing Home 5 \(\supers\) Residence 6 \(\supers\) Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title o certifie ٧ The who completed cause of death (Item 23a) (Type, Print) Himore St. 2000 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene, 24975 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Josephine Elizabeth Holdiness 4:15p M August 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1215 Ridgeshire Road Dundalk Baltimore Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Mir (Month, Day, Year) 1 M 2 X F Months Hours 426-38-2909 84 Yrs. Director Mississipoi September 16,1926 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 Ves 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1215 Ridgeshire Road 21222 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Hospital 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Edgar Pace Eleanor Grace Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Berger Daughter 1215 Ridgeshire Road, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 5, 1 XBurial 2 Cremation 3 Removal from State Rosedale, Maryland Gardens Of Faith 4 ☐ Donation 5 ☐ Other (Specify) Ž011 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21 Signature of Funeral Service Licensi 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End-Stage

Due to (or as a conse ence of): Physician/ Zheimer's disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dilated Condia myspa 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Tes 2 No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 X No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural Certificate: 28d. Describe how injury occurred injury 5 Pendina 2 Accident
3 Suicide 1 Yes 2 No Investigation after death Director; / I in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) , 24 hours ; e Funeral I Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person M. Harrison MD 6095 Marshalee Dr., Elk nide, MD harles Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Records, P.O. Box 68760

Division of Vital

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23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areet, intracedate Cause (Final Scale) (Final Scal	Ĕ	t. Page tment rtant: I		4 Donation 5 Other (Specify	v) E	Bayview	Cremato	ry 8-1	-2011	Baltimo	ore, MD
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANDINI YADAN 5501 LOCHRAVEN BLVD BALTIMORE MD 2123 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	. BOX	ne death ce the attenc ched for us	nysician	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at tin	Fetal death 3		ý			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANDINI YADAN 5501 LOCHRAVEN BLVD BALTIMORE MD 2123 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	000	as beer 2 shou	plet	HYPERTENS	101						autopsy findings available to completion of cause of
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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No							ack, White, y: Whit					
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P.O. Box 68760	res that the death certific signed by the attending I d be detached for use as	Completed by Physician/M	1 Yes 2 No 9 Unknown		4 ☐ Preg 9 ☐ Unki	nant at tim nown	e of death 5	Other (specify)				l IV	ionth	Day Year
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical						occured at the time						ed. ause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year reorge 2011 Medical 4a. Facility Name (If not institution, give str 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 7. Age (In yrs. last birthday) If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. May 6 1935 New York Yrs 094-26-1800 76 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits Director 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified 1 Yes 2X No Pernsylvania Jefferson Hamilton ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 1829 N.Point Road 15744 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 X Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natuuny or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Gross Hinely Eva DeSantis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Hinely - SON 2122 Autumn Haze Court, Gambrills MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 08-04-2011 Baltimore, Maryland 5 Other (Specify) Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland INC 21. Signature of Fur eral Service Licensee 299 Frederick Road, Balto, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury Examiner Disk to for the temperature on other Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 2 N Yes_ Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: ျှ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending 7/23/2011 1 Ves 2 NO Accident 15:00 PW Investigation Dalhwords 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Sonis 2122 Antum Dorlington MI hone Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) 29c. License number 064089

Registrar

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32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JYTY 29, 2011 Physician/ 1:35P M **ASEFEH** MLAN HOMAYOUN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 121 Hunts Bluff Road Sparks Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Min 0570571953 Iran **Director** 212-90-3540 58 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2XXNo Maryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 121 Hunts Bluff Road 21152 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIVo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 Yes 2XXNo Specify. Specify 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Planning Financial Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shariff Hajrasoliha Shams Najm Sadri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 121 Hunts Bluff Road Sparks Maryland 21152 Fariborz Homayoun Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Dulaney Valley Mem Gardens 108/02/2011 |Timonium, Maryland 22. Name and Address of Facility John O Mitchell, IV Funeral Services of ignature of Funeral <u>Dulaney Valley 200 E. Padonia Road Timonium, Maryland 21093</u> 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause ou each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) MULTIFORME Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 1550 OLUETINS ST erriano CRB2, 1M-16 Date filed (Month, Day, Year

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24980 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July ^{Day} 2011 Physician/ Michael Ray Jones Sr. 30 8:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 818 Edgewood Road Harford Edgewood 5. Social Security Number 8. Date of Birth (Month, Day Dec. 11 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 XM 2 | F 61 Kentucky Director 220-52-2819 1949 Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏝 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 818 Edgewood Road 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician Federal Government Be Baltimore, Maryland and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Everette Jones Mildred Naomi Horner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Paulette Jones / Spouse 818 Edgewood Road, Edgewood, MD 21040 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdn 8-5-2011 Aberdeen, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Ent the \ isease, or complications that cause \ the \ eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he at tellure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Mulinunt disease or condition Medical resulting in death) Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veal Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Yes Be (25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 읻 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1001 hraede

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State Registrar 31. Date filed (Month, Day,) AUG 0 5 2011

21215-0036

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Electra <u>Jordan</u> 04 2011 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Towson Baltimore Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 🗆 M 2 🗶 F Days 07/16/1950 Months Hours. Min Yrs Director 091-42-2858 61 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a 602 Berwick Court 21009 U.S.A. items death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian event, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if item 27 is marked other than "--- any injury or other than "---Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Lawrence Goffe Jordan Audrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Hill / Son 602 Berwick Court, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 08/05/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signatur of Funeral Septice Live see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD21076 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Medical death certificate be Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f g 🗍 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1 Tyes been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has page 2 s autopsy Yes To the Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medica examiner? upleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No Accident Investigation 6 Could not be 3 Suicide Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certiffe heck nature and the of certifier 29c. License number 29d. Date signed (Month. Day. Year) 00 who completed cause of death (Item 23a) (Type, Print) 70 Date filed (Month, Day, Year 32. Registrar's Signature State AUG 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24982 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Agatha Veronica Kensicki 0 :30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico If Under 24 Hrs. If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days (Month, Day, Year) 2 - 4 - 1 9 1 0 Maryland 216-66-4179 101 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Co. Rosedale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2346 Hamiltowne Circle 21237 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married tunore, Maryland 21215-0036 al Hygiene. d other than "natural", c If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify Completed 3 Nidowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) 12should be filed with and Mental Hygien Homemaker Home injury or other traumatic event, æ 17. Father's Name (First, Middle, Last) (UNK) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Joseph Mach Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other tram Agatha Czyz/Daughter 2346 Hamiltowne Circle Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-6-2011 Dundalk, MD Rosary Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Caczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death signed by the a 9 I Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes မ HOSPICA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di upleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?

Hospital

State Registrar

Medical

Accident

Suicide

29b. Signature and title of certifier

ettliam

31. Date filed (Month, Day, Year)

AUG 0 5 2011

4 - Homicide

29a. Certifier (Check

Investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1500

2 🗌 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

08-03-2011

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 24983 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Krogman, Jr. AUGUST 11:25AM Lawrence 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A Baltimore Good Samaritan Hospital Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Country) 11777071946 217-50-5625 **Director** Yrs. 64 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b, County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No MD Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21204 20 Dunvale Road Apt. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Drug Treatment Clinic Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wiesner Krogman Julia Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Krieger, Sister 3264 Redbird Lane, Myrtle Beach, SC 29588 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/04/2011 Hillton Svc. Corp. Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. llexandria & Blan 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ACUTE REMAL PAILURE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limiting that initiated events. Due to (or as a consequence of) URINE TRACT IMPECTION attending physician and I for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical LUMG CANCER or Attending Physician: The law requires that the death certificate be STAGE TU 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performe 2 No 1 ☐ Yes 2 ☑ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) avai RP5000 2011 AUGUST 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLVD BALTIMORE GUNEET SARAI 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

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A ROGARD

State of Maryland / Department of Health and Mental Hygie 20

1 - For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:15 PM AROSA BERNICE 01 201 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3414 Liberty Parkway Dunda1k Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-14-1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□M 2₩F 214-26-9159 80 Yrs Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3414 Liberty Parkway 21222 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3X☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done do life. DO NOT use retired) (Specify only highest grade completed) during most of working e filed within 7. at Hygiene. Elementary/Secondary (0·12) Coilege (1-4or 5+) 12 Department Store Employee Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finance and Mental H George Ehrbaker Mary Magdalene Nieberdine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent; if item 27 is m any injury or other treum 3414 Liberty Parkway Dundalk, Maryland 21222 Mary Roxann LaRosa (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 08-03-2011 Towson, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Avenue Dundalk, Dundalk Mary land 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEBILIT **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diatecause. Enter Underlying Cause (Disease or injury Dualty (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 0067635 AUGUST 2011 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Circle Baltimore, MD JESSICA Colburn 5505 Bayrien 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 5 2011 Registrar

			1 - State Registrar	of Maryland		rtment of He			ne 011	24985
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give street and	number)	į	4b. City, Town, or L		(1)	4c. County of Death	
			5. Social Security Number 6. Sex	7. Age In yrs. la	et hirthday)		If Under 24 Hrs.		9. Birthi	place (State or Foreign
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	arylaı shov	'n	10a. State 10b. County		Town or Loc altimo					10d. Inside City Limits 1adYes 2 □ No
	the M	Director	10e. Street and Number	B	al Clino	10f. Zip Code		100	. Citizen of What Cou	ntrv?
	3a or	Ö	4301 Buchanan Avenue	Apt. G		21211		139	United St	
	death	Funeral	11 Marital Status 12. Was E	Decedent Ever in U.S. 1 Forces?	13. W	/as Decedent of His Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Modesi Exemites must be redified at	y Fu	1 ☐ Never Married 2 Married 1 ☐ Yes.	s 2 No		Yes 2. No	Specify:	riidari, etc.)	Black, White, Specify:	Native American
Ö	hours tural"	Completed by	3 ☐ Widowed 4 ☐ Divorced Year o	or Dates:		ent's Usual Occupat	tion	16	b. Kind of Business/In	
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pu	be filed within 72 hours after death with the Marylan rital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be notified at	Be	17. Father's Name (First, Middle, Last)			1		e (First, Middle, Mai	iden Surname)	
yla	should be nd Menta marked imatic ev	ပ္	Daniel Lockner					Unk		
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		19a. Informant's Name/Relationship (Type. Print) Juanita Lockner /Wife						City or Town, State, Zi SS, FL 344	
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Salti	epartn ports ny Inft		21. Signature of Funeral Service Licensee	M01443	22.	Nace and Action	nof Endely Fund	eral Alter	natives	
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8760,	icate be executed physician and s the burial-transit	E	resulting in death) Last Due	to (or as a conseque	ence of):					
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Division of Vital Records,	he faw e has	Completed						autopsy performe	prior to co	ompletion of cause of
ţa	tending Physician: The leath. Ior: After this certificate he the funeral director, page	Be Co	25. Was case referred to medical				26. Place of Deatl	1 ☐ Yes 2 ☐ h (Check only one)	Variation No. 1 ☐ Yes	2 L No
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Sio	Attend death. ctor: / y the fi	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	age of Injury. At home	o form stro		es 2□No	20f Logation (Ctua)	at and Number of Du	ral Pauta Number
<u>></u>	l or A after Direc	Certification: To	determined 206. FI	ace of Injury - At hom uilding, etc. (Specify)	ie, iaiiii, stre	et, lactory, office		City or Town, S	et and Number or Rui State)	ar noute wantber,
	To the Hospital or Attending Physician: within 24 hours after death or the Funeral Director: After this certifica completely filled in by the funeral director;		29a. Certifier 1 Certifying Physician: To	the best of my know	ledge, death	occurred at the time	e, date and place,	and due to the cau	use(s) and manner as	stated.
	the Ho lin 24 the Fu	Medical	(Check only 2 Medical Examiner: On the one) and n	nanner stated.	on and/or inv					
	Vith vith	Σ	29b. Signature and title of certifier)		29c. License		29d	I. Date signed (Month	, Day, Year)
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	_		30. Name and address of person who completed 6	ause of death (Item 2	zsa) (Type, F	EST. B	altimo	re, MD	2120	7
	Sta Registra		AUG 0 5 2011	ause of death (Item 2	park	w.				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2🛣 F Hours (Month Day, Year) 01/19/1923 Director 141-28-9537 88 NJUsual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director the Medical Examiner must be notified 1 Yes 2X No MD BALTIMORE BALTIMORE 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 8911 REISTERSTOWN ROAD 21208 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black White etc. þ filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 XWidowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DAVID HILLER ROSE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARIN LERNER/SON ELMWOOD ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM [08/04/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head railure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ oronan disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 W No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by Division of Vital Records, 3 Probably 4 Wunknown 1 Tyes 2 No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 **D** No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗆 No Accident Investigation after death 6 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifier 29c. License number 2011 completed cause of death (Item 23a) (Type Print) State Registrar

DHMH 17 Rev 7/2009

		•	101	partment of Health and M ertificate of Death		g. No.	24987							
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Frederick Patrick Murphy		2. Date of Death Month July 2	27 2011	3. Time of Death							
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	11:10 A ^M							
rappe !	Funeral		4719 Leyden Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Ellicott City	8. Date of Birth	Howard 9. Birthol	ace (State or Foreign							
ı	Director		122-32-7040 1 M 2 □ F 70 Yrs	1941 New	York									
	land f show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	10	d. Inside City Limits									
	ie Mary ir 28a-1 notifie	Director	MD Howard E	licott City	10	1 ☐ Yes 2 😿 No 10g. Citizen of What Country?								
	s 23a c nust be	Funeral	4719 Leyden Way	21042	10	U.S.A.								
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	1 X Never Married 2 Married 1 X Yes 2 No	3. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 XXNo Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.							
2-00	hours inatura dical E	oletec	15. Decedent's Education 16a. De	cedent's Usual Occupation	1	6b. Kind of Business Ind								
21215-0036	thin 72 ene. than " he Mec	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	ve kind of work done during most of workir DO NOT use retired) Cgency Room Doctor	ng	Medical								
nd 2	filed wi al Hygid d other vent, t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Surname)								
Maryland	12 should be file lith and Mental H 27 is marked o r traumatic eve	욘	Frederick J. Murphy		ret McKei		-1-1							
	nd 2 sho ealth an n 27 is er trau		DIOCHET III	ailing Address (Street and Number or Rural 197 Colonial Drive 1		City, MD 2								
nore	ige 1 ar nt of He t: If iter		1 X Burial 2 Cremation 3 Removal from State cemetery, c	rematory or other place)		0c. Location - City or Tov	*							
Baltimore,	mit. Pa partme portani y injury ce.		21. Signature o Funeral Service	a Memorial Pk. 8-1-2 22. Name and Address of Facility Wi		Clarksville eral Homes.								
m	That I sould start in the sould													
	Pnysician/ Medical		23a. Part 1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, it respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Disease or condition a. Disease consequence of											
	Examiner		Due to (or as a consequence of):	Intery Disease	_		YCS							
	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or linjury											
	execute an and ial-tran		that initiated events resulting in death) Last C. Due to (or as a consequence of):											
09/	icate be executed g physician and s the burial-transit	edical	d											
89	death certific ne attending p ed for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	B ☐ Ectopic pregnancy		23d. Date of delive	ry							
. Box	de de	Physician/N		o Other (specify)		Month	Day Year							
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Division of Vital Records,	require been si should	leted	ty pertension		1 ∐ Yes 24a. Was an		ably 4 ☐ Unknown sy findings available							
Zecc	The law ate has bage 2 a	Completed	Trype in prosenia		autopsy perform	prior to con	npletion of cause of							
ital	Physician: The law this certificate has trail director, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2	26. Place of Death (Check	only one)	/								
of V	ding Phys th. After this funeral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time	tient 3 U DOA 4 U Nursing Hor of 28c. Injury at 2	me 5 Residen 28d. Describe how	ce 6 Other (Specify) injury occurred								
sion	I or Attendir safter death. Director: Af d in by the fu	Certificate:	2	M 1 ☐ Yes 2 ☐ No	28f Location /Stre	et and Number or Rural I	Route Number							
Ο̈Ϊ́	tal or A irs after al Dire		4 Homicide determined building, etc. (Specify)		City or Town,		iodio Nambol,							
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director; page 2 should be detach	Medical	29a. Certified (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Jurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	the time, date and	place, and due to the cau	se(s) and manner stated.							
_	To the	2	29b. Signature and title of certifier	29c. license number		d. Date signed (Month, D								
J			30 Name and address of person who completed cause of death (Item 23a) (Typi	Print)	T	111×39	2011							
/			DAVISSIACKS ON, MI) 1105	-Little Patureiti	7kwy S	uite 210 (a	dun brey My							
	Stat Registra		31. Date filed (Mapth. Day, Year) 32. Registrar's Sanature 33. Registrar's Sanature		/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 24988

		1- For State Registrar				Ce	ertifica	ate of	Deatl	7			Re	g. No.			4120
Physicia	an/	Decedent's Nan	ne (First, Midd	le,Last)						-		2.	Date of Deat	h			3. Time of Death
dical Exami		James F	ranci	s M	arkie	ewicz.	Jr					Ι.	Month July 30, 20	Day 111	Year		1308 hrs
		4a. Facility Name							b. City. T	own, or L	ocation of		,		County or	f Death	
		128 Branch	•					1	Berlin	,					orceste		
	-	5. Social Security				7 0 //	I a a 4 la la 4	١. ماء دا		-4 V	I K I Inda	- 0.41 I I	O. Data of Dist				hplace (State or
Funeral		5. Social Security	Number	6. Sex		7. Age (In yrs.		nday)	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birt	n(MM/D	D/YYYY)	Foreign	n .
Director		214-44-	9812	1 X N	1 2 F	6	5	Yrs.	WOITH	Days	riours	I Walli.	1-26-1946 Country) MD			untry) MD	
-		Usual Residence of Decedent															
any		10a. State	10b. County			10c. City	, Town	or Location	'n							\neg	10d. Inside City Limits
		MD	IJ.O	rce	ster	Co	Rer	lin								21	1 Yes 2 X No
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Mar 28s	Director	roe. Street and No	Imper					- 1	10f. Zip				100	og. Citize	en of Wha		itry ?
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r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Ē	11. Marital Status		T		cedent Ever in L	J.S.						ify Yes or No-	1			can Indian, Black,
eath	nue	1 Never Marr	ied 2 N	larried	Armed F	orces?		lf Ye	s, specify	Cuban,	Mexican,	Puerto Ri	can, etc.)		White,	etc.	
ter d	ᄔ	3 Widowed	4 X Div			"Vietna	o m	1	Yes 2	X No	specify:			S	Specify:	Wb	nite
rs af	ğ	15. Decedent's E	ducation (Spe	cify only	r Dates: highest gra	de completed)	169 1	Decedent'			-	ind of wor	k done		nd of Bus	iness/li	ndustry
Fra t	ompleted	Elementary/Sec			College (during mo						I OD. TU	na or bao	ii icoorii	idustry
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name	•							18			irst, Middle, M		•		
rital fi	Be	James I				ewicz,	Sr	•			Ant	coine	ette E	(rzy	ysty	nia	ak
22 ould i Me	유	19a. Informant's N	ame/Relations	ship (Typ	e, Print)								al Route Num				
y, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner.	.	Bernade	ette E	ask	o/Si	ster	6	810	Du1	uth	Ave	nue	Dunda	alk,	, MD	21	1222
and and tealth term		20a. Method of Dis					Place o	of Disposit	ion (Nam	e of ceme	etery,	С	Date	20c. Lo	ocation - (City or	Town, State
FIGOR, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2	X Cremation	n 3 🗌	Removal fr			ory or othe									
Pag Pag nent		4 Donation 5	Other S	pecify:		Ва	yvi	ew C	rem	atoı							e, MD
mit.		21. Signature of Fu	ineral Service	License	е			22. Na	me and	Address o	f Facility	Kac	zorows	ski	Fun	era	al Home, P
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		100		-	-								nue Ba				
Physician	_	23a. Part I. Enter t	he disease, or	complic	ations that o	aused the death	n. Do no	t enter the	mode o	f dying, si	uch as ca	rdiac or re	espiratory arre	st, shoc	k, or hear	rt	Approximate Interval
Medical		failure. List or	nly one cause	on each	line.											4	Between Onset and Death
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		or condition result	ing in death)	Du	ie to (or as a	a consequence	of):										
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	Examiner	if any, leading to it cause. Enter Unde			io lu lui as a	with a result of the second	υi į.										1
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ertifi ding	a	23b. Was decedent past 12 months		ie	1 Live b			Feta	I death	3	Ectopic	pregnancy	У	1 1	Jon th	D	ay Year
Sox 68 death certi	siciar	1 Yes 2	No 9 Un	known	' -	nant at time of de	eath 5	Othe	er (Spec	ify)							
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es th	by												1 Yes	2	No 3	Proba	ably 4 🗹 Unknown
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law rath	픫												autops			ior to co eath?	ompletion of cause of
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tal Recian: The certificate ector, page	9	25, Was case refer	rred to medica	ı					2	6.Place o	f Death (0	Check only	y one)		<u> </u>		
Vital Rec hysician: The this certificate I director, page	20	examiner?	0 Th-	Hos	spital: 1	Inpatient 2	ER/Ou	utpatient	3 DC	DA O	ther ₄	Nursing F	lome 5	Residen	ce 6 🗸	Other:	Scene
Tal carth	욘	1 ✓ Yes 27. Manner of Dea	2 No		28a. Date			Fime of Inj			at Work?		d. Describe h			-	
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Division of Vital Records, rate of a Attending Physician: The law require rs after death. al Director: After this certificate has been six led in by the funeral director, page 2 should b.	흹	3 Suicide	6 Cou	d not be	28e. Plac	e of Injury - At h	nome, fa	rm, street	factory,	office bui	lding, etc.						al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification	4 Homicide	dete	rmined	(Specify)	Multi-Fam	ily Apt	t.				12	or Town, St 8 Branch St	reet Ap	t. A, Ber	lin, ME)
Hosp 24 ho Func ely f		29a, Certifier 1	CertifyIng P	hysician	: To the bes	st of my knowled	dge, dea	th occurre	ed at the	time, date	and place	e, and du	e to the cause	(s) and	manner a	as state	d.
To the How within 24 h To the Fur completely	<u> </u>	one) 2		miner:0	n the basis	of examination a											
To vii	Medical	29b. Signature and	title of certific		nd manner s	stated.			29c	License	number			29d D:	ate sinner	d (Mon	th, Day, Year)
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1	ŀ	30. Name and add	ress of person	who cor	npleted cau	se of death (Iten	n 23a)		-		_						
. ~		Theodore M	1. King, Jr.	, MD.	Asšista	ant Medical	Exami	ner 9	00 W.	Baltimo	re Stre	et, Balt	imore, MD	2122	3		
St	ate	31. Date filed (Mon	th, Day,Year)		32. Re	egistrar's Signat	ure_	1							-		
Regist		AUG 05	2011	Dens	wa .	egistrar's Signat	rocar										
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11-05689 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James McCreary State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day July 29, 2011 Medical Examiner 1838 hrs James Dean McCreary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre De Grace Harford 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Funeral Months Days Min. Hours Director Country) Maryland 1 X M 213-92-7201 2___F 04/13/1965 46 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No s 23a or 28a-f show e notified at once. MD Cecil yes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23s or 28s-7 she ther traumatie event, the Medical Examiner must be notified at once Aberdeen Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Parke Street 21001 U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes 3 Widowed If Yes, Give Year 1 Yes 2 No specify: 4 Divorced Specify: White É or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Contractor Residential Housing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Stanley Paul McCreary Norma Sue McVey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Yvonne E. McCreary / Wife</u> 425 Dawn Court, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State crematory or other place) 08/03/2011 Anatomy Gifts Registr Hanover, Maryland 4 X Donation 5 Other Specify 21. Signature Funeral Service Li 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only Between Onset and one cause on each line /Medical Death a. Contact Gunshot Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Fuherus after death.
Fuherus after death.
After this certificate has been signed by the attending physician and etty filled in by the funeral director, page 2 should be detached for use as the burial - transition by the funeral director, page 2 should be detached for use as the burial - transition. Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury Jul 29, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot self in presence of police 1 Natural 1820 hrs 1 Yes 2 V No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide 6 Could not be or Town, State) 300 Commerce Street, Tydings Park, MD determined (Specify) In car 24 hours Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 츀 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 30, 2011

OGME

ate filed (Month, State Registra

30. Name and address of perso

Mary G. Ripple M.D.

5 201

ORIGINAL

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

who completed cause of death (Item 23a)

32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

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110

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24991 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen August 2014 Μ. Michel 10:30A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 Aug. 19 Year 1925 Hours Maryland **Director** 85 218-18-7164 Usual Residence of Decedent shov 10a. State 10b County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland| Harford Bel Air 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Funeral United States 108 West Ring Factory Road 21014 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 → No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: AUGUST 3,2011 Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ George Klein Helen V. Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Michel / Husband 108 West Ring Factory Rd. Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Auq. Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Rosedale, Maryland 21. Signature of Juneral Service Licenses Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1 Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or light failure. List only one cause on each line. Immediate Cause (Final NI Onset and Death Physician/ AGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to include cause. Enter Underlying Cause (Disease or linjury Directo Excess a nonseculebre of Exam and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? perforn Hospital or Attending Physician: The certificate 1 Yes Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural work 2 No s after death I Director; A Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title b 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24992 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Ella Juanita Mooney 03 2011 3:13 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X Months Days Hours 83 December 4. 1927 Baltimore, Marylan 214-24-7794 **Director** Yrs Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Parkville Baltimore 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 21234 1644 Wentworth Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ori Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed If Yes, Give White Specify: 3 ▼Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Greetings & Readings 8 Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sylvia Simpson Norman Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McDonough (Daughter) 1032 Hazel Lane Bel Air, Maryland 21014 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of Carrison Forest Veteran 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 9,201 Owings Mills, Maryland 4 Donation 5 Other (Specify) Comptery Signature of Fluneral Service Lig Name and Address of Facility

Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ RIGHT CO REBRAL INTERVENTRICULAR disease or condition resulting in death) Medical HEMMURITAGE. Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atter ō Month Dav Year signed by the at d be detached for g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPER TESION Division of Vital Records, 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? IAL FIBRILLA TIM 24a. Was an has performed After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death Accident Investigation 1 Tes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24993 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Joseph Patrick McGuire 02, 2011 ear 2:00 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death
Baltimore County 4b. City, Town, or Location of Death 501 Spring Ave. Lutherville Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) C. 08, 1919 Months 215-12-2836 91 Days Hours Min. **Director** Baltimore, MD. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Lutherville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Spring Ave. 21093 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 Nidowed 4 Divorced res, Give 1942-45 White Specify. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+)
N/A Production Manager Koppers Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Francis McGuire Clarice Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Steven L. McGuire (Son) 1310 Highland Drive Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland 1 Burial 2 Cremation 3 Removal from State Evans Fureral Charel and Cremation Services, Inc. Thursday Aug. 04, 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Titenses Teffrey L.Gair, Sr.OFS 22 Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093–2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) th Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco se contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 🗌 No Yes 1 Yes 25. Was case referred to dedica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred → Hillural 5 \square Pending injury work? 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 15 049

State Registrar 31. Date filed (Month, AUG 0 5 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Dep	partment of Health a			24994
			1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Dea		3. Time of Death
·	Physicia Medic		William Mogereth		Month	Day Year 201	1 8:00 PM
	Examin	er	4a. Facilify Name (If not institution, give street and number)	4b. City, Town, or Location of	of Death	4c. County of Dea	
			Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore) If Under 1 Year If Under	24 Hrs. 8. Date of Birt	Bruthing 9. Bi	rthplace (State or Foreign
	uneral rector		219-18-7434 1X M 2 F 85 Yrs.	Months Days Hours	Min. (Month, Da)		ountry) ryland
pur	*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Maryla	-f sho	ţo	Maryland Baltimore Dundalk				1 ☐ Yes 2 🔀 No
h the	or 28a	Jirec	10e. Street and Number	10f. Zip-Code		10g. Citizen of What C	
ath wi	s 23a ust be	Funeral Directo	5 Beach Drive	21 222		United Sta	
ter de	r items	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ XMarried 1 □ XYes 2 □ No	. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Am Black, Whi	
215-0036 thin 72 hours aft 8.	al", o	d by	1 Never Married 2 XMarried 1 Nes 2 No If Yes, Give Year or Dates: 1948-51	1 ☐ Yes 2X No Specify:		Specify: Wh	nite
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withir iene.	than the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Fitter		Baltimore	Gas & Electri
aryland 21215-UU36 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		er's Name (First, Middle	, Maiden Surname)	
Yland lould be fill I Mental Hy	arke	To Be	George Morgereth 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ling Address (Street and Numb	a Rosenthal	or City or Town State	Zin Code)
0 W	4 4			ach Drive Dunda			216 (0006)
Ges 1 and 2 it of Health			20a. Method of Disposition 20b. Place of Dis	position (Name of	Date	20c. Location - City of	
Pages ment of	ant: If		4 Donation 3 Dotter (apechy)		08-02-2011	Dundalk, 1	
baitim permit. Pa	Important: If i any Injury or once.			Duda-Ruck Fune 7922 Wise Aven			
			23a art 1. Enter the disease for complications that caused the death. Do not e shock, or heart failure List only one cause on each line.	nter the mode of dying, such as	s cardiac or respiratory a	rrest,	Approximate Interval Between
	sician		Immediate Cause (Final disease or condition				Onset and Death
	edical miner		resulting in death) Due to (or as a consequence of):				2 weeks
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	L EFFUSION			ZWCCAS
cuted	nd transit	Examiner	that initiated events c c.	HEART FAIL	URE		syears
(60), te be executed	iysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):	AKTERY DISE	ACC		17 Mens
te =	g physi as the	Medic		711 101- 1 1150			July
× ē	ending or use	an/N	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of d	lelivery Day Year
that the death	d by the attending phy detached for use as th	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Worth	Day 10a
tat t	64	by Ph	Part II. Other significant conditions contributing to death but not resulting in the			tobacco use contribute	to the cause of death?
ecords aw requires	been signed t should be de		BLADDER CANCER, MYPOTHYRUDIST	n, TYPE II DIA	1-BETES, 10	Yes 2 No 3	Probably 4 🗌 Unknown
a §	co cd	Completed			24a. Was auto		autopsy findings available o completion of cause of ?
VITAI H	pa	e Col	25. Was case referred to medical	26 Place	1 Yes e of Death (Check only o	2 No 1 Y	
(0)	s certificate director, pa	To Be	examiner? 1	Other:	ursing Home 5 Resi		ecify)
In OT	After this certific funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	/ Work?		how injury occurred	
VISION Attending r death.	tor: A	ficati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, \$	M 1 ☐ Yes 2 ☐		(Street and Number or	Rural Route Number,
alor A safter	I Direct ed in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Tov	vn, State)	
DIVISION To the Hospital or Attending within 24 hours after death.	To the Funeral Dir		29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or				
o the l	o the F	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)
₩ 3	1/20		A Kanzwelli	PES-D	00	JULY ?	17, 2011
0	1,2		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			
	Sta	ite.	SHAH S AWAS AW, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature		940 Eastern A	venue, Baltin	nore, MD, 21224
e	Registr		AUG 0 5 2011	garles			

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August John S. Morton, Jr. 201 Tear 3:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Blakehurst Baltimore 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth Days (Month, Day, 1 🛛 M 2 🗆 F Months Hours Min. 92 Director 214-14-8400 Maryland Sept 1918 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore Towson Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a omnust be 21206 1055 W. Joppa Road HC112 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Yes. Give 1 ☐ Yes 2 X No Specify: Completed 3X Widowed 4 □ Divorced Specify: Year or Dates. event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Laura V. Gambrill John S. Morton. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code), 17 Brook Farm Court Cockeysville, Maryland 21030 item 27 John S. Morton, III/ Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 8/5/11 Towson Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Road Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ nenmonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of influiry that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year g Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidnen Records, Disease 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Spina Stenos ate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Matural $5 \square$ Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 142129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N. Charles St. Baltimere 21210 onnell, MD

State Registrar 31. Date filed (Month, Day, Year)

AUG 0 5 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

		State of Maryland / D	Department of Health Certificate of Death		giene 011 24996
		Registrar 1. Decedent's Name (First, Middle, Last)	COMMODIC CO DICTOR	2. Date of De	ath 3 Time of Death
Physici		MARGARET	McELROY	August	2011 8:30 P M
Medi Exami		4a. Facility Name (if not institution, give street and number) HOLLY HILL MANOR	4b. City, Town, or Location	n of Death	4c. County of Death Baltimore County
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	rday) If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Bir Min. (Month, Da Sept. 2	y, Year) Country)
		Usual Residence of Decedent		1 13EµL 2	
land short	ţō	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
Mary 28a-	Director	THE THE BULL DATE TO THE T	altimore		10g, Citizen of What Country?
th the	la l	10e. Street and Number	10f. Zip Code	,	USA
ath w	Funeral	618 Regester Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21212	Origin? (Specify Yes or No-	
or its	by F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexic 1 ☐ Yes 2 🔀 No Specify	can, Puerto Rican, etc.)	Black, White, etc.
ural",		3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates.			Specify: White
72 hou	ple	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b. Kind of Business Industry
u z iz led within 7 Hygiene. other than ent, the M	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	Homemaker		Own Residence
idiliu x IXIODOO be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mo	other's Name (First, Middle,	Maiden Surname)
yidi d be f Menta Menta arked aric e	유	William Lotz		Rose	Kaptain
ITE, INTALYIGHTU ZIZIO-0000 1 and 2 should be filed within 72 hours after death with the Maryland 1 and 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. 1 them 27 is marked other than "natural", or items 23a or 28a-f show 1 other traumatic event, the Medical Examiner must be notified at			Mailing Address (Street and Num		
ore, IN	10	20a Method of Disposition 20b. Place of	Disposition (Name of	Date	Valley, MD 21030
		1 X Ruriot 2 Cremetion 3 Removal from State cemeter	y, crematory or other place) edeemer Cemeter		Baltimore, Maryland
Daltillor permit. Page 1 Department of Important: If it any injury or o		21. Signatury of Funeral Service U.C. sel			AL HOME INC e, Maryland 21212
		Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do n			rrest, Approximate
Pnysician	4	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	DETYENTIA	1-ENDS	Modern Onset and Death
Medica Examine	ıl	disease or condition resulting in death) a. Due to (or as a consequence of	on b condi	12/08/11	in disease
Examine		Sequentially list conditions,	offe conan	WINDLE	IN DIARCE
ed sit	Examiner	if any, leading to immediate Cause. Enter 'Indenlying' Cause (Disease or linjury	n).		
xecut n and al-trar	Exa	that initiated events c. Due to (or as a consequence of the constraint of the constr	of):		
e be e ysicial e buri	dical	d			
oo/o	Mec	IF FEMALE:			
th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
box ne death of the atter ched for u	Physician/Med	1 Yes 2 No 9 Unknown	5 — Other (aposity)		
that the ned by detack	by Pi	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Pa	art I. 23e. Did	tobacco use contribute to the cause of death?
uld be	edb			1	Yes 2 No 3 Probably 4 Unknown
VItal Kecords, ysician: The law requires is certificate has been sig	Completed			24a. Was	prior to completion of cause of
The la	Con			per 1 Yes	ormed2 death? 2 No 1 Yes 2 No
tal ician; sertific ector,	Be	25. Was case referred to medical examiner?	Other	Death (Check only one)	
OT VI	은		itpatient 3 □ DOA □ 4 Time of 28c. Injury at		how injury occurred
on on or or or or or or or or or or or or or	cate	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	njury work? M 1 ☐ Yes 2	2 □ No	
DIVISION tall or Attendii rs after death. al Director: Afed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		(Street and Number or Rural Route Number, wn, State)
DIVISION Of VITAI RECORDS, F.O. BOX 06/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: Orythe basis of examination and/o	death occured at the time, date a	and place, and due to the c	ause(s) and manner as stated.
the Ho nin 24 the Fu nplete	Mec	only one) 3 Certifying Nurse Practioner: To the best of my know	ledge, death occurred at the time, o	date and place, and due to t	the cause(s) and manner as stated.
To t		29b. Signature and title of certifier	29c. License number	o 2 2	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		011/000
		Irene Ibarra, MD, 261 S. Highland 31. Date filed (Month, Day, Year)	Avenue, Baltim	nore, MD 2122	24
St Regis	tate trar	AUG 0 5 2011 Augustars signature.	park		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registraramend 6 per a.b. g922 12/2/1 Cextificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1000 2011 Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 M 2 X July 29, Year 2011 Months 1^{Min} Maryland **Director** INFANT Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event than "the item. 10a. State 10b. County 10d. Inside City Limits 10c. City Town or Location Director 1 ☐ Yes 2 No MD Columbia Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 USA 9428 Chessie Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 Specify: indian 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) INFANT Elementary/Seconday (0-12) TNFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Reshmy Nair M. Nayapulli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reshmy Nair - mother 9428 Chessie Ln; Columbia, Maryland 21046 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Francial Service 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ER/Outpatient 3 DOA Certificate: To Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Investigation Could not be filled in by the Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
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State

31. Date filed (M

A .--

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 24998 Certificate of Death . Decedent's Name (First, Middle, Last) Linda Lois Peters 2. Date of Death 3. Tre of Doath Physician/ 2011 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Angel Assisted Living College Park Prince Georges 5. Social Security Numbe 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11-30-1941 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Country) Texas 1 M 2 😾 Months Days Hours **Director** 452-66-5884 69 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Evanina mandal and injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3407 Marlbrough Court 20740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 🔀 Married þ Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teachers Aide Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnnie Louis Stephenson Bobbie Mae King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Peters (Husband) 1282 Smallwood Drive W. #255 Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Medical, Education
& Research Institute 8-5-2011 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Memphis, Tennessee 21. Signatury of Funeral Service Licens 22. Name and Address of Facility ^{22. Name and Address of Facility} Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ dementia severe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? ASSISTED Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number R143194 Jours 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Digital Dr. # G, Linthicum, Maryland, 21090 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lorraine H. Polomski August 3, 2011 Year 4:15p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 603 S. Ann Street Apt. 520 Baltimore N/A Social Security Number 7. Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X 216-22-4460 **Director** 83 Maryland September 8.1927 Usual Residence of Decedent or 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 S. Ann Street Apt. 520 21231 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mean one. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 10 years Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Ellwood Edler Lottie Lorraine Gremens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Delss Step-Daughter 7402 Poplar Ave. Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 5, 1 XBurial 2 ☐ Gremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2011 Si mature of Fine 2. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ PANCIEN disease or condition Cance Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 4 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperter Sin. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marken 8/4/4 1)16189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$1303 BALTINGE MA ZIRZE Cic KARK 7835 art point mall

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State Registrar 31. Date filed (Month Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Carver Patterson Medical August 2011 9:47 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F 215-50-8697 62 01° Director Baltimore, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Harford Abingdon 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 424 Abbev Circle 21009 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force 0 þ 1 Never Married 2 X Married Black, White, etc. 1 Yes Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0~12) College (1-4 or 5+) 12 Manager <u> Allstate Leasing</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h ျ William Oliver Patterson Helen Marie Tawney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once. Kathleen Patterson (Spouse) 424 Abbey Circle Abingdon, Maryland 21009 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel-Bel August 04, Forest Hill, Maryland Signature of Funeral Service Licenses Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or triagit failure. List only one cause on each line. Interval Between Onset and Death SIS Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Patterson, Richard cause (Disease or iinjury Vascular disease and that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) M80041895 2 🗆 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 🗆 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination allower introdugation.
3 Certifying Nurse Practioner: To the best of my knowledge, death of within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Upper Chesapeake Drive Bel Air, MD 21014

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State

Registrar

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Apruva Desai 31. Date filed (Month, Day, Year)

AUG 0 5 2011